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US will plant scarlet poppies commercially

A four-strand barbed wire fence surrounding land planted with scarlet poppies will be one requirement. But, after long and contentious debate, and with the support of doctors and pharmaceutical manufacturers, the United States government is authorizing commercial cultivation of the scarlet poppy — Papaver bracteatum. One advantage of the scarlet is that it yields thebaine, a rich source of powerful narcotic compounds, including codeine. One disadvantage of large scale poppy production may be the potential for abuse. See page 2.

Carter's interest high

US President-elect Jimmy Carter's interest in drug abuse will give Americans at all levels access to the government, says Peter Bourne, Carter's close associate and former consultant to the Drug Abuse Council. See page 4.

Heroin decriminalization investigation commences

While British Columbia explores the question of making heroin addiction illegal, the US is increasingly embroiled in the matter of heroin decriminalization. The Washington-based Drug Abuse Council is considering what the ramifications would be if criminal sanctions were altered for heroin. See page 3.

Canada has reservations about new UN convention

Canada has reservations about an international drug convention that aims at toughening international drug enforcement practices. One reason for the country's unease with the convention are the proposed cannabis law changes. See page 5.

NZ children win the right to drink in pubs

As governments around the world grapple with the question of how old people should be before they are allowed to drink alcohol legally, New Zealand has voted to allow children not only to visit pubs in the company of their parents but to drink alcoholic beverages as well. In a major social change for that small country, a late amendment to legislation now passed will allow some pubs to have family lounges. The change is aimed at changing social attitudes by allowing families to visit hotels as families. See page 12.

1977 not 1877

Shire horse teams are more economical than trucks on short delivery trips for Young's, a small London brewery that now cannot meet demand. See The Back Page for Britain's 'Campaign for Real Ale.'

Backgrounder

The uniform act that removes public drunkenness from the justice to the health care systems in the United States has achieved more success than any other similar act in recent years. This is the major finding by a research team from Indiana University which investigated the workings of the act in the some 25 states and territories that have adopted it. See Page 9.

Regular features

They're a rich source of narcotics

Poppies get US go-ahead

By Harvey McConnell

WASHINGTON — The United States government after lengthy deliberation and pressure is authorizing commercial cultivation of the scarlet poppy (Papaver bracteatum) for thebaine, a rich source of powerful narcotic compounds.

Potential for abuse resulting from large scale poppy production is recognized by the Drug Enforcement Administration, but it considers the probability of abuse is small. High prices for codeine and the continuing world shortage of opium, its main source, had dictated the decision.

Acting administrator Frederick Rody said in his report on the decision that as extractions from the scarlet poppy do not produce morphine, its potential as a raw material for heroin production is far less than the opium poppy's.

Thebaine is a convulsant at low dose levels and, Mr Rody added, "is devoid of any abuse potential itself".

However, thebaine can be converted into a wide range of substances, especially those called the Bentley Compounds. One of these, etorphine, is used to sedate large, wild animals.

Mr Rody pointed out that etorphine can induce morphine-like euphoria and physical dependence in man. Thus, it could be abused, but its high potency and short action make abuse less likely.

"Perhaps the main telling evidence that thebaine derivates will not become drugs of choice of illicit users is the fact thebaine has been available as a natural alkaloid of opium for many years and its derivatives have never caused any measurable abuse problems."

Whatever the scientific considerations, the DEA will see that all production will be "fully consistent with adequate security and accountability to ensure against diversion of thebaine to the illicit traffic".

This will mean limited production, controlled acreage, destruction of all surplus plants and extractions, and DEA inspection at any time of cultivation and production.

Land planted with scarlet poppies must have at least a four strand barbed wire fence, a resident farmer or manager, a daily perimeter inspection, and instant access to the police.

Any fields near metropolitan areas must have additional security, including a chain fence and watchdogs.

Mr Rody, in outlining the reasons for the decision, said requests to authorize cultivation and extraction of thebaine from the scarlet poppy for conversion to codeine and other narcotic and non-narcotic drugs has become urgent over the past year.

Several pharmaceutical companies "now believe they are able to show that domestic growth and processing would offer cheaper and more dependable raw material supply than is possible as long as the United States continues to rely on imports for raw materials."

The American Medical Association backs the move.

Mr Rody said it is apparent that natural codeine and opium derivates will be needed in the forseeable future, "contrary to hopes that better synthetic substitutes would be developed to replace the need for opium".

World demand for opium based drugs — particularly codeine — has increased at more than 4% a year for the past decade. In the same period, America's demand for codeine has grown at approximately twice the world rate.

The supply of raw materials has not kept pace with demand. Back in 1973, Congress allowed 283 tons of opium from the national strategic stockpile to be processed, which provided a secure supply and permitted a cushion for the world until poppy production could be increased.

The situation had improved slightly by 1976 but the level reached has not been enough to provide an adequate safety margin.

Mr Rody said that at the same time the shortage has been overtaken by cost. In the past two years, the price of codeine phosphate in the US has doubled to $1,050 per kilogram. Even with increased world production there is little chance prices will return to previous levels.

Mr Rody, in his report in the US Federal Register, said proposed strict quota limits on production, at least until 1981, are necessary so the delicate world balance of supply and demand is not upset.

In 1975, a seed crop of the scarlet poppy was grown at the West Montana agricultural research station.

Guard dogs and barbed wire fences

Experimental blood test shows up heavy drinkers

NEW YORK — An experimental blood test to detect chronic alcoholism has been developed by a team of researchers here.

The test is not a predictor of who will become a heavy drinker but a determinant of who is a heavy drinker, according to Charles Lieber.

He, Spencer Shaw, and Barry Stimmel, from the Bronx Veterans Administration Hospital and the Mount Sinai School of Medicine, City University of New York, described the test in *Science* (Dec).

It involves taking a blood sample from a patient and calculating the ratio of two amino acids, alpha amino-n-butyric acid and leucine, in the plasma fraction of the blood.

For unknown reasons, this plasma fraction was found to be more than twice as high in alcoholics as in non-alcoholics. In addition, because the substances measured persist in abnormal amounts after alcohol disappears from the blood, the researchers found that the new test could detect alcoholism even after heavy drinkers stopped drinking.

The New York team did studies on hospital in-patients and ambulatory alcoholic patients and healthy non-alcoholic volunteers. The abnormality was unrelated to the patients' nutritional status, being found in both well and poorly nourished alcoholics.

The test may be done in any laboratory that has spent up to $50,000 for an amino acid analyzer, and the researchers are using the test to evaluate various treatments in industrial and rehabilitation clinics for alcoholism.

However, Dr Lieber said he considered the test experimental and not available for routine use until independent teams of researchers had verified the results.

He added that the primary challenge to his research team is to determine the mechanism by which alcohol produces the biochemical changes that were measured by the test. The researchers have determined that the test results reflect prolonged rather than short-term intake of alcohol, that the test remains positive more than a week after the long-term drinking period ends, and that it tends to become negative as the alcoholic begins abstinence.

"At this point we know what the test means — it is associated with heavy drinking — but we do not know how the abnormality comes about," said Dr Lieber.

WHO study planned

GENEVA — The World Health Organization is planning a research project on the effects of alcohol-related problems on the family and the wider community.

Local research teams in three selected countries will study these problems (as well as the social, physical and mental effects of alcohol on the individual) along with current methods of dealing with them. WHO hopes the findings will provide a basis for more effective community planning and response to the problems.

Scotland, Zambia, and Mexico will be the first three collaborating countries in the project. WHO says the selection of two countries considered near the extremes of development from the technological, economic, and health points of view, and one undergoing very rapid change, should mean the study results will be of value to a wide variety of communities.

A search has now started for a suitable project manager to lead the research team in Geneva and to work with local investigators in the collaborating countries.

WHO's long-term objective is to develop an international network of centres for exchange of information and experience on research, training, and action programs concerning alcohol-related problems. Toward this end, selected investigators from countries other than Scotland, Mexico, and Zambia will be invited to collaborate in the current project.

David Archibald and Reginald Smart from the Addiction Research Foundation of Ontario have discussed with WHO officials the possibility of establishing one of the study areas in Ontario.

Prof Bottomsworthy to the rescue once again

By Wayne Howell

"Did you know," I said to Professor Bottomsworthy, "that because you have appeared in my column in **The Journal** so many times in the past, the editor has commissioned Gail Geltner to paint your portrait in charcoal."

Always astute, the good professor was not impressed by this flattery.

Professor Bottomsworthy (a.k.a. Wayne Howell)

"You didn't come here to tell me that," he said. "If you had a good idea for a column — one of those cute little allegorical stories you are so inordinately fond of — you wouldn't be here, would you."

"You're right," I confessed.

"If some conference speaker or report writer had come up with some new jargon word or phrase you wouldn't be here, you'd be flailing away at that wouldn't you?"

"Right," I mumbled, becoming embarrassed.

"And if you were in one of your raffish moods, you'd be home banging out Tom Wolfish prose, trying to make up for the lack of substance with a supercilious style and an abomination of alliterations. Right?"

I had to admit that Professor Bottomsworthy had me pegged.

"So why don't you come right out and say that you are stuck. When you are stuck you always come knocking on the old professor's door. And if I don't say something amusing or outrageous you don't have a column. Right?"

The professor was really rubbing it in.

"You have to consider my position," I countered feebly. "Satire thrives on inanity, irony, and incongruity. Not to mention hypocrisy. It is not my fault that the A & D scene isn't what it used to be. The silly sixties are no longer with us — there is a general lack of dubious theories, dumb pronouncements on the subject of marijuana, and goofy wastes of the taxpayers' money. There just aren't that many people promoting simple-minded solutions to drug problems anymore. I even have trouble thinking up simple-minded solutions myself."

The professor seemed genuinely touched by my last remark. He put his hand gently on my shoulder.

"I didn't realize," he said, "the depths of your desperation. But fortunately you have come to the right man. My inventory of simple-minded solutions to complex problems is matched only by my vast store of complex solutions to very simple problems."

This was the Professor Bottomsworthy I knew and loved.

"Now in the first place," he continued, "you must stop feeling badly that you have nothing to say. That has never stopped some A & D spokesmen from making speeches and so I don't see why you should let a little thing like that get in the way of a column; if the conveyance of useful information or original insights was a prerequisite for public discourse on the subject of A & D then very little would ever get said, written, or reported.

"So, do not feel badly that you are, at the moment, bereft of an idea. If I were you I would just keep on as you have been doing, padding out the column with extraneous and irrelevant material, always giving the impression that it is going somewhere, working towards a climax, but ultimately saying nothing much of anything that hasn't been said by someone somewhere before."

"They wouldn't print something like that in **The Journal**," I said.

"Well you never can tell," said Professor Bottomsworthy thoughtfully. "You cannot automatically assume that they apply higher standards to their columnist than they apply to people they report on who speak at conventions, symposia, and other public gatherings."

(Wayne Howell is an Ottawa physician and freelance writer.)

Heroin: It's time to consider the options

WASHINGTON — A major study of the ramifications if criminal sanctions were altered for heroin is under way by the Drug Abuse Council.

Director Tom Bryant hopes that until the report is ready in a year or so, the temperature will

Tom Bryant

be lowered and the controversy about heroin muted.

The study, and its recommendations, may reflect the swan song of the privately-financed council which now, with reduced staff and funds, is devoted entirely to issues of public policy.

Dr Bryant said the investigation by a number of experts inside and outside the council will try to separate and analyze as many facets as possible of the problem.

"This means to define it. What does it mean by 'decriminalization' — which is an unsatisfactory term — and then what would that mean?

"There are several things you could be talking about, such as removing criminal sanctions for possession of small amounts for personal use only, and for everything else you would use criminal sanctions.

"Or, it could go all the way up to, and include, creating a very rigid, controlled distribution system which might, or might not, involve heroin maintenance, and there would be no criminal sanctions other than for major trafficking."

Trying to analyze the impact on the justice system, the economy, and the community are just as important.

Dr Bryant said that on the community level, for example, "if it is no longer a criminal offence to possess a small amount of heroin for personal use, what would that do in a black community?

"What would it mean to the mother who is now competing with an illicit black market if she were then competing with a legally sanctioned market in terms of trying to keep a kid off drugs?"

The study has grown "out of the sense that the timing is right to consider options," Dr Bryant said.

"We get a lot of calls and letters about heroin decriminalization and heroin maintenance — and a lot of people confuse the terms — and I find, as I travel, an increasing interest in doing something with heroin. We have been overpromised by the drug abuse and treatment people and none of it has occurred.

"There is a sense of boredom and frustration at the other approach."

Like many things that people fear, if some of the emotion can be lifted and the subject considered coldly, "then you might be able to do things you cannot do when you are hysterical.

"You can at least now, and I do this all the time, have less than heated discussions about heroin and criminal sanctions. Three years ago you could not do that."

At the same time, Dr Bryant is at pains to point out that while the Drug Abuse Council is considering the options, it is in no sense "pro-heroin".

It is similar to the earlier situation in which the Drug Abuse Council called for removal of criminal sanctions for possession of marijuana. He points out: "There is nobody, certainly on the board of directors and myself, who is in any sense 'pro-pot.'

"We don't like to see marijuana used, but the fact is that millions, particularly young people, have decided they just don't like our drugs, they like pot.

> **'I think most of the things associated with heroin in the minds of most people are indeed the myth of the 'devil drug.'**

"If you look at it realistically, and decide how it is least disruptive to society to handle marijuana, how do you pay the least social price and/or incur the least social cost, then removing criminal sanctions certainly makes more sense than what we have been doing."

Heroin seems the most important of all because it is perceived to be the most important. But, comparatively "I don't think it is nearly as damaging to the fabric of society, for example, as alcohol, and probably not as damaging as nicotine.

"I think that most of the things that are associated with heroin in the minds of most people are indeed the myth of the 'devil drug'."

Dr Bryant believes the Drug Abuse Council has always tried to take a hard and realistic look at drugs. "Drugs are with us, and probably always will be, and we believe it is better to learn how to live with them as best we can and, to use the common jargon, 'minimize the harm'."

The heroin study and aftermath will carry the council to the end of 1978 when present funding is scheduled to end.

At the end of 1975, when its original lifespan was up, the board of directors voted to extend it for another two years, even though the funds were not yet available. The Ford Foundation, which has always put up some 75% to 80% of the money, agreed to carry on while others gave amounts that could be stretched over the next two years.

One previous backer, the Carnegie Foundation, dropped out.

Dr Bryant noted that many of the past efforts, such as large research grants and fellowships, are no longer needed. Staff has been reorganized and pruned to 25 members from 40.

The presidential election also took a toll as the council lost the services of Dr Peter Bourne, one of President-elect Carter's principal aides.

Looking at the immediate future, Dr Bryant hopes that for the next year or so, the question of heroin remains sotte voce. "It needs a lot less attention, and hopefully won't get a lot.

"If you get attention, it is always the wrong kind of attention. What we need is quiet consideration until our report is out."

Ontario's alcoholism treatment services

Task force will suggest improvements

By John Shaughnessy

TORONTO — The Addiction Research Foundation of Ontario has set up a task force to develop proposals for improving alcoholism treatment services in Ontario.

ARF president, Dr John B. Macdonald, says many of the costs of providing health care for alcoholics are not covered by the government, and the existing services fall short of meeting the spectrum of genuine needs in this area.

Further, in his opinion, service facilities for alcoholics in Ontario, although numerous, are highly variable in almost all respects. The result is that the system "appears to be inefficient and in some instances treatment is probably less effective than it could be. The network of care in Ontario, as a result, is costly to the community especially if measured against success rates."

The task force, which is expected to provide a report within a year, has the long range goal of helping to implement a network of facilities and services under the auspices of the Ontario government, "tailored to specific goals, based on specific standards, and designed to reach specific afflicted populations in the most effective and economical way consistent with current knowledge."

In a letter urging ARF staff to cooperate with the task force, Dr Macdonald said the Addiction Research Foundation itself is not responsible for providing the needed treatment services, but it does have a responsibility "to propose ways in which Ontario can meet its treatment needs dealing with alcohol, making the best possible use of its resources already in existence, and filling in the gaps in a systematic way."

Joan Marshman

'We want to know what specific groups of alcohol-hurt people can reasonably expect in terms of treatment.'

Decisions concerning the adoption of the ARF recommendations and the taking of action are matters of public policy and therefore the responsibility of the government, he added.

Joan Marshman, head of pharmaceutical sciences in the ARF's Clinical Institute Research Division, will head the task force.

Dr Marshman says it's difficult to say now what the major directions will be. As a starting point, the task force will identify "discrete populations" of alcoholics in the province, and then attempt to define specific treatment goals for each group.

"We have to find out what we have right now. Existing treatment facilities may be attempting to deal with populations that overlap. The vast amount of information on alcoholism in Ontario that is available is in bits and pieces.

"We want to know what specific groups of alcohol-hurt people can reasonably expect in terms of treatment. Once we've pulled it all together, then we should be able to recommend a reasonable approach to filling in any gaps we find."

Other task force members include: Dr R. D. Fraser, department of economics, Queen's University; Dr Paul Humphries, senior medical consultant, Ministry of Correctional Services, Toronto; Dr Camille Lambert, faculty of social work, University of Toronto; Dr Douglas Macdonald, director of clinical services, The Donwood Institute, Toronto; Dr Alan Ogborne, scientist, evaluation studies, Addiction Research Foundation; Dr James Rankin, director, Clinical Institute, Addiction Research Foundation; Dr Sally Saunders, medical consultant, Metro Toronto Region, Addiction Research Foundation; and Dr Wolf Schmidt, director, social studies, Addiction Research Foundation.

Dr Macdonald noted in his letter that the task force includes people who have had extensive experience in providing services for alcoholics, researchers in this field, and others "whose expertise in public policy and health economics can contribute to fulfilling the terms of reference".

The specific terms of reference as outlined by Dr Macdonald include:

- Identify the discrete populations of alcoholics in Ontario requiring separate treatment goals and/or methods. Estimate the numbers in each group and their distribution in Ontario according to type of community and geographic location.
- For each distinctive population of alcoholics, identify the specific goals of treatment.
- Provide a descriptive title for the service appropriate to each type of population, e.g. detoxication centre, halfway house, out-patients clinic, in-patients clinic etc.
- Provide a description of methods appropriate to each of the goals and each of the populations.
- Identify the minimum unit size (in terms of staff) for each service unit compatible with operating it with fulltime personnel. Identify the patient capacity of each service unit.
- List the kinds and numbers of staff required for each service unit.
- Describe the minimum physical plant requirement for each service unit.
- Identify the population required to justify each type of service unit.
- Estimate the number of service units of each type necessary to meet the province's needs.
- Relate the number and location of each service unit required to the existing resources.
- Estimate the operating cost for each type of service unit on both a per unit and per patient basis.
- Estimate the total additional costs to modify existing services and, where necessary, establish and operate each type of service unit.
- Propose priorities for the phasing-in of the various service units.
- Identify manpower implications of establishing the various service units and suggest appropriate training requirements to meet identified weaknesses.
- Develop a critical path covering all of the above designed to provide a report to the president in a period of one year.

Feds are holding their bite on the breath testing laws

OTTAWA — Chalk up another victory for the federal government in its continuing legal battle to keep teeth in its alcohol breath test legislation.

A man arrested two years ago in Liverpool, Nova Scotia, on suspicion of impaired driving, has lost his right to appeal to the Supreme Court of Canada. He had contended that the Royal Canadian Mounted Police would not allow him to make his own telephone call to his lawyer.

The case had been previously lost in the Nova Scotia Supreme Court; the highest court in the land decided it wasn't worth hearing, at least based on the facts of the case.

The man had been taken to an RCMP detachment for a breath test after being stopped in a Liverpool parking lot. At the police station he had started to take the standard test when he asked to telephone a lawyer.

The police decided he was incapable of making the call himself. They noted he had fallen off his chair several times.

They said they would do it for him, left to make the call, and returned later saying they had been unable to reach the man's lawyer.

When the man continued to refuse to resume taking the tests, he was charged under the Act with refusing to submit to a breath test — a charge which, on conviction, carries a penalty similar to those for failing the test.

Before the Supreme Court of Canada, the man's lawyer argued that the case should be heard on the principle that if police are allowed to make telephone calls to lawyers for individuals, there might be abuses. People then could lose their right to seek legal advice when being brought to a police station.

Supreme Court Chief Justice Bora Laskin said he agreed with the principle but felt the facts of the case didn't warrant hearing the appeal.

Judge's stand is 'intriguing'

WASHINGTON — A lower court judge in Massachusetts "much to the surprise of at least the defence team" has dismissed the case against a young man arrested for possessing $20 of cocaine.

Defence attorney, Joseph Oteri, said not only was the decision by Judge Ellwood McKenny unexpected but also that his findings were intriguing.

Judge McKenny ruled that American drug laws were hypocritical and a waste of resources and that alcohol and tobacco were more harmful than cocaine. He said cocaine was not a narcotic and was an acceptable, recreational drug.

Mr Oteri cautioned that the decision was made in a lower court, not an appeal court, and thus it was not binding in future cases.

Carter will listen says Bourne

By Harvey McConell

WASHINGTON — Jimmy Carter as president will maintain his deep interest in the entire drug abuse field and his administration will be a receptive listener.

This was suggested by Mr Carter's long-time confidant Peter Bourne in an address to the fifth annual conference here of the National Organization for the Reform of Marijuana Laws.

The whole question of drug abuse has always been a deep personal concern of the president and Dr Bourne said: "I can attest to that from my own experience working with him in Georgia.

"He took a personal interest in programs, read a great deal, and became extremely knowledgeable about drug abuse. In fact, a lot of the time I got worried he was getting to know a lot more about it than I did, which was a bit disconcerting."

In addition to this, Mrs Carter has asked her husband to establish a presidential commission on mental health, which she will chair. Said Dr Bourne: "I don't know the scope, but I think it will include drug abuse and alcoholism, not necessarily as the primary emphasis but these will be covered in the broad purview that the commission will look at."

Dr Bourne made it plain: "When you have this kind of interest in the White House, in the areas in which we are concerned, it really forces the rest of the country to examine the pros and cons of issues in a much more practical way.

"People can't go on ignoring the problems or sweeping them under the rug. I think this kind of interest will be sustained and it will be an interest that people around the country then will keep up."

Dr Bourne said he hoped that during the next four years there will be a more practical approach to problems.

"I know there are going to be disagreements on the means and the goals in some of the areas, but I hope, above all, one thing we can maintain is an open dialogue, and that we can be available to people of the broadest possible concerns and interests.

"There may have to be disagreements about the way things are accomplished, but I hope there will not be any disagreement about the opportunity to have input, to have an ear, to have people who will listen."

Outsiders then will be able to feel "that you have receptive listeners in the administration and that there will be deep concern in all of the issues that you are concerned about".

Dr Bourne referred to the specific question of lifting criminal sanctions on marijuana, which Governor Carter favored during the campaign, and said he thinks Mr Carter "believes in it not just because of things people around him have said, but . . . for the same reasons all of us do."

As Governor, Mr Carter saw at first hand, people forced to spend time in prison for possession of small amounts of marijuana, and the lives of some of his personal acquaintances or their children, destroyed.

How his feelings will be translated into action is still an open question.

Mr Carter, at present, "favors leaving decriminalization to the states, partly because he believes there are individual variations in attitude from one state to another, and it is probably appropriate for groups outside the government to help to bring about changes in the states where it can be accomplished, rather than trying to impose, on the federal level, a blanket policy".

Dr Bourne said Mr Carter will look at the pros and cons "and do what he thinks best, and not just make an arbitrary decision".

Mr Carter's administration will survey the position of federal agencies in the field and consider the potential for reorganization or the restructuring of roles.

Dr Bourne emphasized health education.

"I think the amount of good that could be done by health education in this country in providing people with more information — and I'm not just talking about drugs and alcohol but the health field in general — I think and I hope that would be an important shift in federal policy in the next four years."

In answer to questions, Dr Bourne said: "The issue of combining drugs and alcohol is a constant colloquy and about having one agency instead of National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, and I'm sure that discussion is going to go on throughout the next four years. Where it is going to come out I don't know."

Dr Bourne said also he felt there is a very important distinction between lifting criminal sanctions on marijuana and making marijuana legal.

"The difference is between encouraging the commercial exploitation of grass, and maintaining a posture of discouragement, but without making the penalties totally injurious to the person.

"My personal feeling is that we should maintain a message out there that you are better off not to use any drug at all."

Peter Bourne and Jimmy Carter

Ontario five-drug study

Sex differences seen in drug use

By John Shaughnessy

TORONTO — Income and locality may play a role in whether adult males in Ontario are heavy or frequent drinkers.

A study commissioned by the Addiction Research Foundation of Ontario suggests heavy drinking — five or more drinks at a sitting — is most common in males, young people, and those in the highest income groups. Frequent drinking — every day — is most common among males, young people, those in large urban centres, and those in the highest and lowest income categories.

The study reports a survey conducted last June of the use of five drugs in the Ontario population aged 18 and over, as determined in a Gallup household survey. In total, 1,015 adults were interviewed.

Overall, 80.5% of the total sample reported drinking alcoholic beverages in the past 12 months, 8.6% used sleeping pills, 13.7% tranquillizers, 5.8% marijuana or hashish, and 0.7% stimulants or pep pills at least once.

In a special sample of 111 males aged 18 to 21, more reported drinking and using marijuana and stimulants but fewer reported using tranquillizers and sleeping pills.

The special sample of males was added because household surveys often miss young people, especially males, who are absent from the home when the interviewer calls.

Authors of the study, Dr Reginald G. Smart and Dr Michael S. Goodstadt, from the foundation's evaluation studies department, also point out that the value of self-report surveys lies in giving a general view of the minimum level of alcohol and drug use. "Such surveys should be cautiously interpreted and are perhaps of most value in indicating long term trends or where substantial differences in use are likely to be found."

In an interview with **The Journal**, Dr Smart said that "for some reason people report more accurately when asked about their use of psychoactive drugs than they do when asked about their alcohol consumption. There may be as much as 50% under-reporting in alcohol use surveys, while people seem to report about 75% of their actual use of psychoactive drugs."

With these limitations in mind, the authors report that their survey revealed statistically significant sex differences in the numbers of users of all drugs except stimulants.

About 11% of females used sleeping pills, compared to only about 8% of males. About two and a half times as many females as males reported tranquillizer use (19.3% compared to 8.3%). Almost three times as many males as females reported the use of marijuana or hashish (8.2% and 2.3%).

More males than females were drinkers of alcoholic beverages (85.7% and 75.2%) but the difference was relatively small compared to that with the other drugs.

The survey found that the use of sleeping pills varied by all characteristics considered except mother tongue and education. Of those more than 50 years old, 14.6% used them, but use of sleeping pills was reported in only 4.7% of those aged 18-29 and 6.2% of those aged 30-49. Use was greatest among those having occupations in the "other" category — retired, unemployed, housewives etc., and it was most commonly reported by interviewers in Metro Toronto and least often by those in Eastern Ontario.

The use of stimulants was reported by only 0.7% of those interviewed. However, according to the authors, there were suggestions use was most common in Northern Ontario, in smaller centres, among those with low incomes and public school education, and those speaking French as a first language.

Tranquillizers were most often used by those beyond age 30, people with clerical or sales occupations, and high school or university educations. As with sleeping pills, they were most often used by people living in Metro Toronto and in large centres.

Marijuana use was most common in those aged 18-29 (17.6%) and no one over 50 reported use. Geographically, use of this drug was most common in urban centres, in Metro Toronto (12.9%) and Western Ontario, and least in Northern and Eastern Ontario. Reported use was twice as common among English speaking as French speaking people, and was highest in the professional or executive groups, those with the highest educational levels, and with the highest incomes.

With respect to alcohol, the authors said 80.5% of the study subjects reported drinking within the past year, and there was a "somewhat higher" frequency of drinkers in Northern Ontario compared to other areas.

Almost 32% of subjects reported drinking mostly beer, 17.5% mostly wine, and 28.3% mostly liquor, the remainder drinking equal amounts in various combinations. Most respondents (68%) reported doing most of their drinking at home; 15.4% drank most at a friend's home, and the remainder drank mostly in various public and private licensed establishments.

Examination of the frequency of use of drugs and alcohol indicated about 63% of users of sleeping pills, 48% of tranquillizer users, 45% of stimulant users, and 28% of drinkers, take their drug once a month or less often.

Frequent drug use (every day) was most common for users of stimulants (36.4%), tranquillizers (20.3%) and sleeping pills (21%) and least common for marijuana (10.6%). About 13% of drinkers reported drinking every day.

Drinking every day was associated with a variety of characteristics but not with occupation or geographic region. It was most common among males, those aged 30 to 49, and those who reported French as their first language.

Daily drinking was about twice as common in large urban areas as in small ones. It was also most common among those in the lowest and highest income and education categories and least common in the middle categories.

BC eases drinking rules but tightens enforcement

By Tim Padmore

VANCOUVER — New provincial liquor laws were proclaimed in British Columbia last month easing some restrictions on drinking but providing for stricter enforcement of regulations.

Consumer and Corporate Affairs Minister Rafe Mair said that effective December 31 the old liquor act was to be repealed and replaced by two new acts, providing:

- Consumption of liquor in public areas, including parks and campgrounds;
- Sale of beer and BC cider at sports stadiums;
- Opening the doors of liquor stores on provincial and municipal election days;
- Use of agents and sampling rooms by breweries, wineries, and distillers.

The legislation also:

- Sets stiff penalties for selling liquor to a minor and defines acceptable identification — a passport, driver's licence, or BC identification card, obtainable from the motor vehicles department;
- Provides for 24-hour licence suspensions if pub patrons behave in a rowdy manner;
- Prohibits liquor ads on TV and radio and ads that associate drinking with a desirable lifestyle.

Parts of the legislation, which was passed but never proclaimed by the former New Democratic Party government, were not put into effect.

One section not proclaimed would have allowed the sale of hard liquor in pubs, an omission which has brought cries of outrage from hotel owners, some of whom had already ordered dispensing equipment in anticipation of a favorable announcement (**The Journal**, December).

The regulations give considerable discretion to local municipalities, which are to have the final say whether such things as drinking in sports stadiums or campgrounds will be allowed.

The municipalities will also have the power to specify the kind of entertainment allowed in pubs, which may mean the end of nude stripper shows, another blow to pub owners.

Canada balking at UN enforcement convention

By Bryne Carruthers

OTTAWA — Canada has refused to go all the way in toughening up international drug enforcement as proposed under a recently ratified international drug convention.

With no fanfare, but with proposed cannabis law changes in the back of its mind, Canada has agreed to ratify "with reservations" the protocol strengthening the 1961 United Nations Single Convention on Narcotic Drugs. It came into effect in Canada in 1976.

The "reservations" have been placed next to three paragraphs amending Article 14 and relating to automatic extradition by Canada of drug offenders for crimes defined under the amended UN convention .

The Journal has learned Canada is balking at accepting the automatic extradition provisions primarily because they would have forced Canada to extradite people to other participating countries for crimes that are not sufficiently serious in Canada to warrant extradition.

In particular, the Canadian government was concerned about the status of cannabis offenders under the extradition section of the amended UN drugs convention, which lumps cannabis with heroin and other hard narcotics.

Under proposed and overdue changes to Canadian law, the government will move cannabis crimes from the stringent Narcotics Control Act, long regarded as the Canadian equivalent to the UN Single Convention on Narcotic Drugs, to the considerably less stringent Food and Drug Act, which covers mostly medical drugs.

Justice department and external affairs department officials told **The Journal** that Canada traditionally does not consider food and drug offences, in particular ones proceeded by summary conviction and those involving simple drug possession, to warrant extradition under existing and planned extradition treaties with Canada covering drug offences.

Yet, under the protocol amending the UN Single Convention, participating countries would have been required automatically to extradite individuals to other convention countries if the drug crimes were covered by the amended convention — this not withstanding existing or future bilateral extradition treaties between Canada and those countries.

Of concern to Canada is the fact the amended convention includes such drug offences as cultivation, possession, purchase, and offering of illicit drugs, and includes such drugs as cannabis (marijuana, hashish, THC).

Canada is currently trying to strengthen its own bilateral extradition treaties by renegotiating many existing treaties to include drug offences which are illegal in Canada as being extraditable offences. For example, while drug offences are considered extraditable in a treaty with the United States, they are not covered in agreements with France and Spain.

Eventually, Canada plans to have drug offences included in all extradition treaties, but based on its own principle of "double criminality," that is where the offence is a sufficiently serious crime in Canada as well as in the other countries to warrant extradition.

In simple terms, an extradition treaty with another country allows for the other country to demand that people convicted or charged with crimes in its jurisdiction be returned to the country by Canada. Existing treaties specify the crimes and conditions under which Canada will agree to participate in an extradition.

Adequate representation of minorities a major problem

Politics could blur true concerns

SAN FRANCISCO — Adequate representation of minority group interests is becoming one of the major problems facing drug abuse planning authorities in the United States.

But a start towards heading off potential confrontations and politicking which could obscure the true drug abuse concerns of minorities is being attempted by those planning the 1977 National Drug Abuse Conference, to be held here May 5.

The conference, which has as its theme a multicultural view of drug abuse, will include both "culturally specific" and interdisciplinary task forces. In addition, according to conference chairperson David Smith, minorities will play a part in task forces other than those specifically designed for their particular groups.

The culturally specific task forces will deal with issues concerning the aging and youth, women, gays, Native Americans, Asians, Blacks, Chicano/Latinos and Puerto Ricans.

Tommy Chung, director of Asian-American Drug Abuse Program, Inc. in Los Angeles and Asian Task Force chairperson, said he hopes the conference "will start to provide an opportunity for minorities to express their concerns in drug abuse treatment and prevention."

Similarly, 25 interdisciplinary task forces have been set up so those in the fields of study, practice, and policy that have some impact on drug and alcohol use and abuse may share ther concerns and ideas.

For example, the social scientists' task force will be examining different cultural evaluations of drugs such as marijuana, and the task force on family therapy will deal with such topics as how the family initiates destructive patterns of behavior in adolescents.

> **"It is difficult to decide sometimes what is a real issue and what is just politics."**

Dr Smith says the early response of minorities to the conference has been enthusiastic, but it has also forced some rough political decisions to the surface — such as who has the right to represent whom where constituencies are so ill-defined; and how do you achieve balanced representation without encouraging battles over turf?

Another difficult task is separating the "rhetoric from the substance". In the recent past, said Dr Smith, "the tactic was always to be angry, always to demand more. It is difficult to decide sometimes what is a real issue and what is just politics."

The conference structure has been set up to allow the cultural and minority groups to react through the national and regional task forces, or directly through a group of chairpeople who have been selected on a regional basis (Matthew Gissen, Miami, Southeast; William Harvey, St. Louis, Midwest; Ralph Gaetano, Johnson City, NY, Northeast; Arthur Simmons, Seattle, Northwest).

In a field as broadly based as drug abuse, there are a lot of constituencies to be served, says Dr Smith. And the emphasis has been to open up the conference as much as possible.

He admits politics is a potent factor in any multicultural environment, and in one such as drug abuse programming where funding is tight, the politics can become volatile.

"It should be a goal not only of this conference but of the entire field of drug abuse, not to let politics get such a stranglehold that it engulfs the true reason for being."

David Smith

US wants world agreement on drugs

By Charles Marwick

WASHINGTON — Americans are spearheading an attempt to draw up an effective international agreement aimed at strict control of narcotics and the source.

The proposal that an international conference of elected officials and law enforcement experts be held to achieve this, probably in Geneva, came from US Congressmen Lester L. Wolff (Democrat-New York State).

The conference would draw up a worldwide network of anti-narcotic agreements that would halt the "present unacceptable situation where some 90% of the illegally grown drugs find a way to the consumer nations," said Mr Wolff.

The proposal parallels one attempted several years ago during the Nixon administration when the US made a bilateral agreement with Turkey to stop opium poppy cultivation. The difference this time is that the attempt, at least in its proposed form, is multi-national in scope.

Mr Wolff is chairman of a select committee on narcotics abuse and control established by Congress last year in an attempt to coordinate legislative moves with US government efforts in the drug abuse field.

Late last year, the committee accompanied by Drug Enforcement Administration head Peter Bensinger visited seven countries in the Middle East and Europe to discuss the possibility of reaching agreement with the various nations interested in controlling illicit drug traffic and especially with producer countries.

"We came to the conclusion," said Mr Wolff "that to be effective the attack on drug abuse must begin at the source. Once the raw product leaves the farms, there is no way to follow it in its process form to its ultimate destination."

At a press conference held by Mr Wolff, DEA administrator Bensinger strongly supported the proposal.

"Drug abuse is no longer an American problem," Mr Bensinger said. He said 20 kilograms of heroin from South-east Asia was recently seized in Rome and in 1975, 200 people in West Germany died from drug overdosage.

"The cultivation of opium poppy must be controlled," he stated. "This will require government dedication to crop eradication, complimented by consistent enforcement that uncovers and properly punishes offenders who continue to plant these illegal crops."

Discussing his visit to France, Switzerland, Egypt, Pakistan, Afghanistan, Italy, and Germany, Mr Wolff said: "We were able to sit down with elected and appointed officials of the nations directly concerned with an inadequate attack on narcotics to discuss the nuts and bolts of reality of why over 90% of the narcotics being produced currently get through to the user nations.

"In the case of Ganistan and Pakistan which by themselves produce opium nearly equal to the entire output of the Golden Triangle, we were able to break a diplomatic logjam on agreements to provide direct technical aid on the war on narcotics."

On his proposal to hold an international conference, Mr Wolff held the US must take the lead in setting up meetings of legislative, law enforcement, and health experts. The conference would complement present United Nations efforts, but be free of some of the broader political questions currently hampering the UN's work in other areas, he said.

"The nations most hard hit by narcotics — both the producer and the user nations — must sit down face to face and hammer out agreements similar in teeth and intent with other international agreements that bind nations to specific actions."

Program's for beginning drinkers

BC tries out controlled drinking

By Tim Padmore

VANCOUVER — Controlled drinking, the object of heated controversy recently, is being tried for the first time in British Columbia in a program for beginning alcoholics.

The Vancouver Health Department and University of BC psychologists started in November to teach people skills to help them keep their drinking below limits they set themselves.

UB psychology professor Lynn Alden said she hopes the program will attract people who don't think they are alcoholics and are reluctant to think they may be headed in that direction.

"We aren't aiming at hard core drinkers, at people who have lost their jobs or families and are on a downwards spiral. Nor are we after those who are abstinent. We feel someone who is abstinent should stay that way," she said.

That stance takes the Vancouver program out of the main line of fire of opponents of controlled drinking, who say a goal less than total abstinence is dangerous because it invites relapse.

She described the program, which is modelled after one at the University of Oregon, as "very promising" after one year of operation.

The idea is to find out why the drinker drinks, and then tailor strategies to help him cut down.

If the drinking is to relieve tension, he is taught relaxation and meditation techniques.

If the problem is relating to other people, he is given "assertion training".

If the reason is insomnia, going-to-sleep tricks are explained.

"Many people don't know why they drink and it seems to motivate them when they see that they drink when they're angry, or tense, and not just 'because they like it'."

Everyone in the program is taught to calculate their blood alcohol content, using their body weight and the number and timing of drinks.

People choose a BAC limit themselves — most set it about 0.06%, she said, but some choose zero, and others may even choose limits higher than the 0.08% level that defines impaired driving.

Drinking techniques are modified. A heavy drinker tends to gulp his drinks, disdain mixes, and chain drink. Consumption may be cut dramatically simply by teaching the drinker to sip, order cocktails, and space his drinks.

"We also teach people how to refuse drinks. Many just don't know the words or attitudes to use," Prof. Alden said.

"People are willing to say they're controlling their weight, but they're reluctant to say they're controlling their drinking."

Said Vancouver medical health officer Fred Bass:

"It's okay to overdrink, but it's not okay to worry about it."

The program, conscious of the stigma of the label of alcoholic, avoids the term. Its own upbeat title, Skills for Non-addicted Drinkers, reflects this.

Dr Bass said the department is supporting the project in the hope of cutting down death, illness, and injury resulting from excessive drinking.

He said between 2% and 8% of the population are problem drinkers, adding that the major health problem associated with alcohol is not alcoholic debilitation but injuries sustained by drinkers and innocent people in traffic mishaps.

Cocaine use vogue highlights paucity of data

By Dorothy Trainor

QUEBEC CITY — A major liability of cocaine use is the strong reinforcing property which in some users may lead to a compulsion for the drug and to serious social and psychological consequences, says Richard B. Resnick.

On the other hand, he says, for some individuals cocaine use may be chronic but does not escalate in frequency and apparently carries little or no serious risk.

Dr Resnick, director of the division of drug abuse research and treatment, department of psychiatry, New York Medical College, has, with Elaine Schuyten-Resnick, been studying cocaine's subjective, behavioral, and physiological effects since 1974.

He says the increase in non-medical use of the drug has only highlighted the paucity of data on its effects.

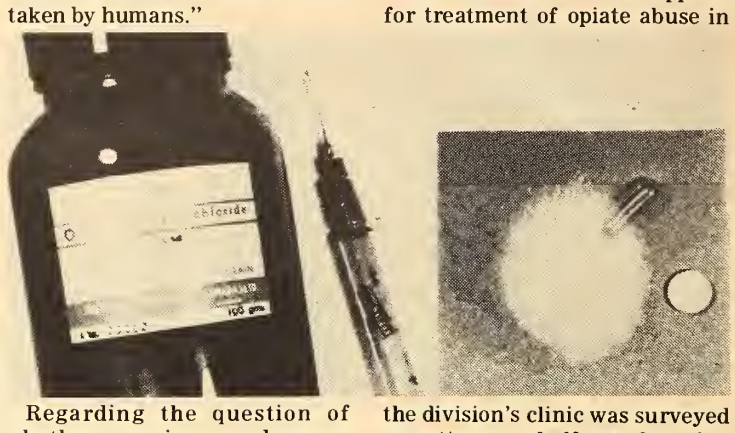
In an address here to a meeting of the Collegium Internationale Neuro-Psychopharmacologicum, Dr Resnick described a study in his division in which data were gathered from 75 regular users of cocaine.

As for cocaine's purported aphrodesiac quality, he said: "For many, it is considered the drug of choice to enhance sexuality. Users report it produces more intense sensual feelings, particularly tactile sensations, and that it prolongs sex by delaying orgasm. Some say it increases ability to fantasize and they are able to talk about, or act out, their fantasies which they might be either disinterested in or too inhibited to do without cocaine.

"Although some individuals say that when cocaine is applied to the penis, it increases erections, it is more commonly reported that cocaine inhibits erections in men."

One point made by Dr Resnick concerned cocaine's subjective effects. Many individuals reported periods of daily use but none reported experiencing a difference in subjective effects from the first to the last day of use when they used cocaine of uniform potency.

"We suspect that the reports of sensitization in animals and the lack of this effect in the groups of people we interviewed may be explained by a cumulative drug effect in the animal studies where doses far exceed doses taken by humans."



Regarding the question of whether cocaine produces a psychotic reaction, Dr Resnick said paranoid ideation is often associated with the "set" in which cocaine is taken rather than with a specific pharmacological effect.

"Individuals who had experienced paranoid feelings when self-administering the drug have been struck by the absence of this effect when they receive it in our laboratory."

Nonetheless, he agreed the possibility exists that cocaine can induce hallucinations and paranoid ideation.

Only 10% of the clinic sample believed they had a "problem" with cocaine. Three-quarters of these said they would elect for treatment if such treatment were available, while the remainder saw the problem in terms of expense. "It keeps me broke."

They were interviewed regarding their patterns of use and also provided subjective reports. Supplementary information was obtained from four users in private psychotherapy who had been using between $200 and $1,000 worth of cocaine weekly.

Another group of more than 200 individuals who had applied for treatment of opiate abuse in the division's clinic was surveyed on patterns and effects of cocaine use. In this group, 199 of 212 had used cocaine at least once. Laboratory data were obtained on 50 people.

User types fell into the five patterns established by the US National Commission on Marijuana and Drug Abuse governing the spectrum of drug abusing behavior — experimental, recreational, circumstantial, intensified, and compulsive users.

Dr Resnick said that in the "intensified" category, cocaine users take the drug daily and tend to space each dose "as if trying to achieve a sustained rather than an intense effect".

"Most individuals herein snort the cocaine from three to 20 times a day, each individual having a dose schedule from which he rarely deviates, so long as supplies are available. Some use it as often as every hour; others only twice a day."

In the compulsive group, said Dr Resnick, users take the drug for episodic or sporadic binges to get high. The binges may occur from once a week to once or twice a year and may last for hours or days. They are similar to alcohol binges. People in this group use large quantities of the drug for days until either the supply or the money runs out.

An effect seen in all categories was behavioral.

"Some individuals in each of these groups experience an often overwhelming compulsion or craving to take more as soon as the acute effects have subsided.

"For this reason, although cocaine is known to be non-addicting — it does not produce physical dependence — many individuals develop a strong psychological dependence on it. Laboratory experiments with animals have demonstrated beyond dispute that cocaine is the most powerful reinforcer of all psychoactive substances.

"Some interviewees reported that at times the drug must be made unavailable to them in order to break the cycle of compulsive use. One such user reported having spent $24,000 insurance money over a three-month period — all on supplies of cocaine."

But, for many other users, Dr Resnick said there is no such liability. In fact, some users report the contrary. They prefer using cocaine to many other drugs because it is short-acting and they regard it as relatively safe.

US adopts 'Lifestyle'

WASHINGTON — A Center for Public Communications has been established by the US Department of Transport to spearhead its drive on drunk driving in America.

The centre, under Paul Fields, has already drawn extensively for guidance on the Canadian government's Operation Lifestyle program for alcohol (The Journal, Nov 1976)

Pilot public service commercials have been produced on the theme Friends Don't Let Friends Drive Drunk. They urge that rather than let friends drive home drunk, people either let them spend the night, call them a taxi, or drive them home.

Mr Fields said the centre is also working with the National Council on Alcoholism to develop a project for industry which several large companies will soon test out on their employees.

One of the ways suggested to encourage responsible behavior is to require special training for all employees whose duties include driving. The same program would be offered voluntarily to all other employees.

Blood pressures rise with heavy drinking

By Jean McCann

MIAMI BEACH — Heavy drinking appears to be associated with a medically significant rise in blood pressure.

This is one finding in what is probably the first large-scale study of the relationship between drinking and blood pressure levels in a large group of imbibers of both sexes and of various races. It was reported here at the annual meeting of the American Heart Association.

Arthur L. Klatsky of the Kaiser-Permanente Medical Center in Oakland, California, also announced that:

- a "clinically significant" rise in blood pressure generally correlates with an increase in the amount of alcohol intake.
- the correlation between hypertension and alcohol is more concrete for diastolic blood pressure — when the heart is resting between beats — than for systolic pressure.
- taking three or more alcoholic drinks daily is generally associated with a rise in blood pressure, but having two drinks or fewer, is not. In fact, in the case of women drinkers, the lesser level of drinking is associated with *lower* blood pressure than in non-drinkers.
- only in heaviest-drinking white males is there a correlation between fatness and higher blood pressures.
- the association of blood pressure and alcohol intake is independent of age, sex, race, smoking habits, coffee use, blood type, educational attainment, or a heavy drinking history.

Dr Klatsky said the alcohol-blood pressure study was conducted during the multiphasic screening of individuals undergoing health checkups over a four-year period at the Oakland and San Francisco Kaiser-Permanente facilities. Subjects were aged 15 to 80 years, and slightly more than half were women.

About four-fifths were white, one-eighth were black, 3.9% were Orientals, and 3.7% were Indians, Polynesians, and people of unknown racial background.

In response to a question about alcohol consumption, 24.2% of the respondents said they had drunk no alcohol in the last year, 57.2% said they drank two or fewer drinks daily, 7.7% from three to five, 1.4% six to eight, and 1%, nine or more: 8.6% did not respond to the question.

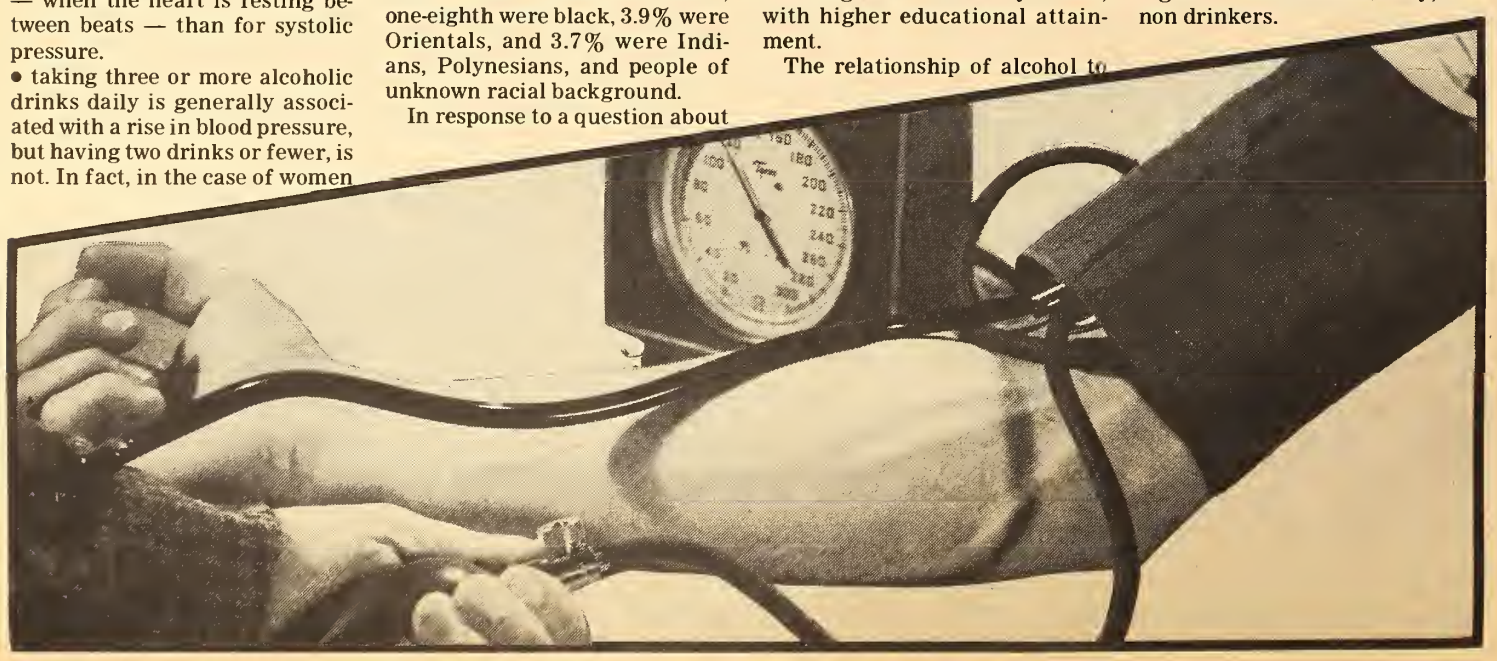
As a general finding, he said, "men drank more than women, drinking was most prevalent among whites and least prevalent among yellows, and the proportion of drinkers decreased in the older age groups.

"Alcohol use showed a strong positive association with cigarette smoking, and a weaker positive association with coffee use. There was a strong association of current alcohol use with 'yes' responses to a question about past heavy drinking."

Results also showed there was a greater number of individuals drinking two drinks a day or less, with higher educational attainment.

The relationship of alcohol to adiposity was not a simple one, however. "There was little relationship of adiposity to drinking in black men, and no clear trend among yellow men. Among white and black women, the *non*-drinkers had the greatest adiposity. The two or less per day drinkers, and the three-to-five-per-day drinkers, were significantly *less* adipose than non-drinkers among white and black women."

Dr Klatsky said in trying to determine the significance of hypertension as related to alcohol, he considered the relationship of blood pressure to age. Age-adjusted data, however, showed mean systolic blood pressure was slightly higher among the two-drinks-a-day or less group of white males, and rose gradually, to reach an 11 mm Hg difference between those taking six or more drinks a day, and non drinkers.



While black men, as expected, had generally higher pressures than whites, alcohol appeared to make less difference in them than in white males.

Orientals, however, followed the white pattern, with a progressive rise in systolic pressure as compared with non-drinking yellow men.

In white women who drank heavily, a progressive rise was also shown in blood pressure from the three-plus drinks a day level upward, although the rise was less precipitate than in the males. Paradoxically, the mean systolic level was about 3 mm Hg *lower* in women of all three races who took two drinks or less per day.

Black women, however, in the three-drinks-and-up category showed mean systolic blood pressures which were "quite similar to those of black men at the corresponding drinking levels".

The researcher said diastolic blood pressure, showed a lesser relationship to drinking patterns than did systolic.

"Among white and yellow men, the diastolic blood pressure was progressively higher with greater alcohol consumption but among black men, diastolic blood pressure seemed to level off at three-plus drinks per day."

Among women of all races, those who drank two or fewer alcoholic beverages daily had somewhat lower diastolic, as well as systolic pressures than non-drinkers.

Dr Klatsky noted, however, that women in this category were also less fat than those who imbibed no alcohol, which might account, at least in part, for their lower blood pressures.

Pot smoking increases while other drug use levels.

Saturation point may be here

Most drug has use levelled

By Harvey McConnell

WASHINGTON — Marijuana smoking among American high school students has increased over the past year but the use of other drugs has levelled off, according to two studies for the National Institute of Drug Abuse.

Director Robert DuPont says that while the reports show a stabilizing trend in drug usage compared with increases in the 1960's and early 1970's, "the drug problem is a big problem and it is not going to go away".

He cannot explain the apparent levelling off, but Dr DuPont postulates that a saturation point may have been reached and there are not a lot more people who wish to use drugs.

One flaw in the studies carried out by Georgetown University and the University of Michigan is that a large number of people in the age group most prone to drug use are not included.

Investigators confined interviews to people living in "households" and there were no interviews with college students living in dormitories, or with homeless young people. This could mean the amount of drug use has been underestimated.

'...The drug problem is a big problem and it's not going to go away...'

The study by the Social Research Group at Georgetown found that the use of drugs, other than marijuana, has remained fairly constant over the past two years. No increase was reported in the use of heroin, cocaine, or hashish, and there has been no change in LSD usage.

One in 20 of all people interviewed has used an hallucinogen at least once, the same figure found in 1972. The largest numbers of users were in the 18-25-year-old group where one in six reported having tried an hallucinogen at least once.

The Georgetown study found that among those aged 12 to 17, use of marijuana rose 9% (14% to 23%) in 1972-74. However, in 1975 it remained constant at 22%.

In other age groups, the use of marijuana has remained fairly constant.

The study by the Institute of Social Research at Michigan showed that among 17,000 members of the high school classes of 1976, there was a significant increase in the use of marijuana compared with the class of 1975.

Among the 1976 graduates, 53% admitted using marijuana. In the classes of 1975 the figure was 48%.

High school seniors classified as current users — they had used marijuana in the month preceding the survey — rose from 27% in the 1975 classes to 32% in the 1976 classes.

Overall, some 8% of the members of the classes of 1976 said they were daily marijuana users.

Occasional use of marijuana was disapproved of by 55% of all the 1975 graduating students. In 1976, the figure had dropped to 48%.

Some 25% of those graduating in 1975 thought marijuana usage should be considered a crime.

An overwhelming 92% of the graduates were against using LSD, even once, and 64% thought there was a great risk in trying it.

12 CNS stimulants in proposal

US may ban amphetamines for fat

By Harvey McConnell

WASHINGTON — A ban on prescriptions of amphetamines for obesity will shortly be introduced by the United States Food and Drug Administration.

However, amphetamines may not be removed from the market entirely and doctors would still be able to prescribe amphetamine-like compounds for weight problems.

Dr Richard Crout, director of the Bureau of Drugs within the FDA, said his agency expects to have evidence presented in the near future that amphetamines are a major cause of drug abuse, despite controls already in force.

When the evidence is received offically, the FDA will move to withdraw the doctor's right to prescribe them for obesity.

Many doctors have called for amphetamines to be banned entirely. They point out that retention of the amphetamine-like compounds will still leave on the market drugs which are habit forming and which may be abused.

Some 12 compounds, which are central nervous system stimulants, are involved in the future ban. At present, no repeat prescriptions for amphetamines are allowed and production by pharmaceutical companies is limited.

Alcoholic relapse is 'no more than a challenge'

By John Shaughnessy

HALIFAX — Alcoholism is essentially a relapsing disorder, and acceptance of this basic fact is as important for those treating alcoholics as it is for the alcoholics themselves.

In most cases, an initial relapse is no more than a challenge and an opportunity to learn from previous mistakes and to try again, says Max Glatt, consultant in charge of the Alcoholism and Drug Dependence Unit, St. Bernard's Hospital, London.

"Inexperienced staff often feel that success in treating alcoholics means the alcoholic achieves total abstinence for 'the duration', and they become frustrated, disappointed, and dejected if a patient to whom they have given a lot of dedicated attention relapses soon afterwards, and possibly does so again and again."

Speaking to a seminar on recidivism, sponsored by the Nova Scotia Commission on Drug Dependency here, Dr Glatt said majority opinion still strongly feels that the only safe goal for an alcoholic is total abstinence as a condition for a future happy, contented, and useful life.

On the other hand, he said, probably the great majority of recovered alcoholics who have had no drink for many years, have achieved this happy state of affairs only after a varying number of initial relapses.

The newcomer-therapist in the field of alcoholism may take a client's or patient's relapse as evidence of his own (the therapist's) failure, or come to feel that the task of helping alcoholics is beyond his own or anyone else's reach.

"One has to realize that many alcholics with very inadequate personalities, for example some skid row drinkers, will probably never be able to maintain sobriety for very long. For such very damaged or very unstable personalities the therapist will often have to be satisfied with a much more modest success than lifelong total abstinence, with temporary improvement rather than recovery."

Dr Glatt stressed that temporary improvement in such inadequate personalities means relative success. "It means a great deal not only to the sufferer himself, but probably much more to his long-suffering family if, instead of being on a more or less persistent, chronic bender, he may have a 'skid' only every month or so, and if in the interval he has started to work, and has become a caring husband and father.

"The therapist who has learned emotionally to accept this view of alcoholics will still feel sad about a patient's relapse but will be able to continue working with alcoholics without too much frustration, in the knowledge that ultimately many such initially relapsing alcoholics will finally recover, and others may continue to improve, as evidenced in the longer intervals between relapses, in the lesser duration and intensity of their 'skids', and in their improved style of living."

A realistic appreciation of the nature of alcoholism as a relapsing disorder, of the limitations of a given individual's potential, and of the improvement following a previous admission, is also important in deciding how often to readmit a "recidivist" to treatment.

According to Dr. Glatt, everyone would agree that just limiting readmission to one or two occasions would be unfair and that the decision would have to be handled on an individual basis and probably made after a staff discussion.

"An individual who showed no evidence of trying or of improving (after treatment) would probably hardly at all qualify for readmission, although one might have to consider the destructive effect of such a drinker's 'acting out' and drunken behavior on the family, and therefore perhaps give him one more chance. If an individual cooperated well during his stay, and if subsequently he showed evidence of certain improvements in life style and length of sober episodes, these would be factors favoring his chances of readmission even though he may have had a number of previous admissions."

On the other hand, Dr Glatt said, consideration must be given to the negative effect which a high number of readmissions may have on the morale of the staff, and perhaps even more important, on other new patients.

"Meeting a large number of patients who have had a number of previous admissions may have a detrimental effect on the motivation of newcomers. A too lax handling of readmission procedures may also lower the motivation of former residents to try their best not to drink again."

Pumping action of heart is inhibited by alcohol

MIAMI BEACH — New evidence that alcohol inhibits the pumping action of the heart was presented to a session of the annual convention of the American Heart Association.

A study reported by Jeffrey N. Retig of the division of cardiology at the Mount Sinai School of Medicine, City University New York, also indicated how this takes place — by inhibition of calcium uptake.

Dr Rettig said his study in dogs was designed to indicate whether the depression in contractility of the heart might be due, in part, to a lowering of the amount of calcium available for release to the contractile proteins in the heart.

What he found, he told the AHA session, was that "the protein kinase-stimulated calcium transport by cardiac sarcoplasmic reticulum is more sensitive to ethanol than is basal calcium transport. The increased ethanol-sensitivity of phosphorylated sarcoplasmic reticulum may reflect interference with the action of the phosphoprotein on the calcium pump."

His study showed that while basal calcium transport was inhibited by 19% by 1 M ethanol, the protein kinase-stimulated calcium uptake was inhibited 42% by the same concentration of ethanol.

Dr Retig said the concentrations of ethanol sufficient to produce inhibition "are above the lower level of the lethal range of blood ethanol concentration in man".

No smoking over US air?

WASHINGTON — A proposed ban on all forms of smoking on United States commercial airlines has been delayed by the Civil Aeronautics Board until it receives more public comment on the proposal.

The CAB decided in October last year that cigarettes, cigars, and pipes be banned and then invited interested consumer groups to present arguments.

An extension was asked for by Action on Smoking and Health (ASH), which proposed originally the new restrictions, and the board extended the time until the end of January.

The Tobacco Institute has already protested the ban, and said that passengers who smoke are already forced to sit in less desirable seats in the rear of aircraft.

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Letters to the Editor

Normals/villains?

I'm subscribing to **The Journal**, for another year, since you may be encouraged to examine and support Peter Bourne's comment (**The Journal**, Oct 1976) that heroin decriminalization is an intelligent approach to a formerly small problem that has been turned into a major disaster by our 50 years of an irrational, heavy handed, expensive narcotic prohibition policy and the many weird efforts used to try and enforce the unenforceable. Since Dr Bourne is a health advisor to the new US president, his comments have great significance, because Canada's non-alcoholic drug policies are based on US views, experience, and legislation.

Much of **The Journal** is devoted to endless repetitive articles about alcohol abuse. It is clear that widespread, casual use of the drug alcohol creates ever more moderate users and ever more addicted users. The only way to control the social and physical damage is to reduce overall consumption by raising prices and de-glamourizing use of this dangerous drug. Even though there are 70 times more alcohol addicts than narcotic addicts in Canada, the majority of alcohol drug users do not fear becoming addicts because they know they are not mentally or physically susceptible to the drug. However, individuals find it more comfortable to rationalize their basic need for alcoholic drugs and to procrastinate endlessly about methods to end the abuses. So, perhaps it is time to drop the pretence anyone really wants to be cured even partially of their craving for alcohol or to condemn the pushers and traffickers engaged in spreading use of this drug who are allowed to hide behind the mask of respectibility.

Considering the monstrous social and physical damage done by, and the addictive potential of, alcohol there is real justification for trying to eliminate the gigantic alcohol drug problem by employing the cruel attitude, techniques, and vast sums of money now directed toward the less troublesome tiny group of narcotic users . . . Just imagine the cries of anguish from our hypocritical 'normal' alcohol drug users if they were subject to the ghastly treatment these new aristocrats consider proper to inflict upon the abominable lower classes who dare to use a different brand of drug (locking them away in prison and forcing them to buy drugs at inflated prices from an illegal source where quality control is non-existant is very humane).

This sort of vicious double standard stinks and it is time **The Journal** dared to make an effective effort to dispel the myths and misinformation used by 'normal' alcohol addicts and prescription pill poppers to justify their addictions by exaggerating the dangers of narcotics and pretending narcotic users are the villains.

R. L. Foster
Chartered Accountant
Burnaby 2, B.C.

'Let's quit booze and schmoking again this year.'

Al-Anon impressed

We have read the November issue of **The Journal** and were most impressed by the attention you paid on page five to the families of alcoholics.

Al-Anon, an established resource for families of alcoholics, provides information and help for the family whether or not the alcoholic seeks help, or even recognizes the existence of a drinking problem.

Although an outgrowth of Alcoholics Anonymous, with the same basic structure, Al-Anon, which includes Alateen, its teenage component, is a completely separate organization. The only membership requirement is that there be a relative or friend with a drinking problem.

On behalf of all those suffering because of another person's drinking problem, we wish to express our appreciation.

Margaret O'Dea
Public Information Coordinator
Al-Anon Family Group Headquarters Inc.
P.O. Box 182
New York, NY 10010

Inside Science

Ontario DWI progra

By Pamela Ennis

Researchers who attempt to evaluate the effectiveness of social programs are often confronted with the phenomenon of 'blind faith'. Those who are involved in the development, implementation, and administration of such programs, as well as program participants, may be convinced of program efficacy simply because of the time and energy which has already been invested.

As a scientist who is concerned with the development and evaluation of intervention strategies in the area of impaired driving, I have frequently encountered this blind faith attitude in the literature and among program personnel.

Of course, given the magnitude of the drinking-driving problem, the belief and hope that one's program is actually having some impact is not hard to understand. However, basing impaired driving programs solely on blind faith is a costly practice, both in terms of the resources required to establish such interventions, and the consequences should the program have no effect on those drinking-drivers who pass through the system.

We need objective evidence on whether our countermeasure activities in the area of impaired driving are fulfilling their goals, and how existing programs may be modified to become more effective. In this paper, I describe an evaluation currently underway on the Oshawa Impaired Drivers Program.

The Oshawa DWI Program, initiated in 1974, has several goals. Chief among them is the prevention of recidivism in those second offenders convicted of a DWI offence who are referred to the program. In addition, there is a concern with effecting positive knowledge and attitudinal changes about drinking-driving among program participants. Finally, an attempt is made to guide those individuals who feel they can no longer handle their drinking problem into approriate treatment. All second-time DWI offenders in the Oshawa area are referred to the program through a probation order. Over the nine weekly sessions of the course, resource persons (ARF staff, police officers, physicians, social workers) show films and lead discussions about drinking and driving. Some of the topics covered are the effects of alcohol and other drugs on driving ability, the drinking-driving laws, the effects of drinking on the family, how to cope with stress, how to recognize problem drinking, and where to go for treatment.

To determine whether the DWI program is achieving its goals, it is necessary to compare program participants to another group of second-time DWI offenders who did not pass through the course. Unfortunately, *all* eligible offenders were referred to the course during its first two years, eliminating any possibility of a control group. Furthermore, there were so many individuals being sent to the course that by October, 1976, more than 100 people were still awaiting entrance. This backlog posed a serious problem for the course administrators, who felt most comfortable working with only 15 offenders per session.

A new procedure was suggested which not only eliminated this backlog but also created an acceptable research design. In the present evaluation, the meaning of "DWI program" has b panded to include not actual classroom sessions, a situation where su ticipation is not require Judge Dodds and Judge son are continuing to second offenders in the area to the "program", t agreed to permit the sub random assignment of t dividuals either to the act course or to straight pr Through randomization, possible to attribute any differences between the tr and control groups to th course.

Both the course group probation control gro required to complete eva materials to measure kn and attitude changes at th ning and end of each nin session. In addition, all indi must complete the Mortim kins, a diagnostic measure at discriminating probem social drinkers. Personal mation, including BAC l time of arrest, is also bei lected. Offenders in bo course and probation c groups will be followed-up

Pot reformers move onto centre stage

THE SWEET smell of success came easily to the fifth annual conference of the National Organization for the Reform of Marijuana Laws (NORML). Surface manifestations were stainless steel brilliant — opulence and power.

Gone were the bad days with cramped Maryland motel rooms and Cat Stevens records. This time, Capitol Hill could be seen from the conference in a hotel of myriad chandeliers and a conversation-stunting fountain Bernini might have given a second glance.

And the ultimate accolade. As speaker, Peter Bourne, whom everybody but everybody knows is so close to Mr Carter.

Plus "the media" — network cameras and all. Cool, so cool.

Dr Bourne reminded the conference that issues once regarded as being on the outside of the general flow of events have moved onto centre stage. "I was amused to read in *The Washington Post* that, according to them, I was just coming to another establishment convention."

Every delegate had his copy of the just-released federal Strategy Council on Drug Abuse report which says America pays a relatively high price for its policy of criminal sanctions against marijuana and urges a look at options.

Marijuana still fascinates, as anyone seeing CBS's news report of Dr Bourne's speech could testify. With the "spontaneity" so beloved by the TV eye, delegates smoked as they sat around the large dinner table to listen. Seldom during the conference itself, however, did the outsider notice any acrid interruptions.

Glaucoma patient Bob Randall's *legal* marijuana cigarettes engendered in photographers, as they closed in on his plastic box with its tatty contents, a reverence usually reserved for such monuments of pictorial history as the diamond bedecking Elizabeth Taylor's capacious bosom.

Harvey McConnell comments on the NORML conference held in Washington, D C Reports next month

Success may bring euphoria, and blind spots, and the faithful had to be reminded things are really not what many of them seem to think.

Asked by an eager delegate after his speech if he felt "the revolution had been won," Dr Bourne was quick to reply: "There's a long way to go yet. I think things are moving in the right direction, but that's all one can say at the moment."

Scientific gurus reiterated their frustrations in trying to use marijuana as a legal medical aid.

It took rugby-hardened lawyer, Michael Stepanian, the Andromeda of NORML's legal stars, to bring things down to reality.

On the final day, he lamented that at past conferences he had met with "a little bit of love and a little bit of understanding for each other."

Now, voguishness had taken over. To remind themselves of that, he asked everyone to hold hands for a few seconds. "We are not so cool . . . we are not so sophisticated . . . we want to be loved. Stop big-timing with your egos and trying to be cool and trying to niche out a little piece for yourself. There are still a hell of a lot of carcasses along the way that we have a lot of responsibility for."

No doubt Armageddon has been bypassed. But the prophets know there are steep hills before Jerusalem.

Backgrounder

Report exonerates public drunkenness act

WASHINGTON — Indiana University researchers were prepared for the worst when they began extensive visits last summer to find out how well the act removing criminal sanctions from public drunkenness was working.

Rumors had been circulating that it was not working well, or even that it was a failure, in some of the 25 states and territories that have adopted it since 1971.

By Harvey McConnell

Their findings are the reverse in the just-issued report from the Institute for Research in Public Safety at Indiana done for the Council of State and Territorial Alcoholism Authorities in Washington.

"The Uniform Alcoholism and Intoxication Treatment Act is one of the more successful pieces of uniform legislation promulgated in recent years," they have concluded.

There are flaws, of course. Some are major. But as Lynn Buttorff, a member of the team and also a staff member of CSTAA found, hardly anyone wants to turn back the law.

This is true, especially, of the people who are always in the middle, the police. Time after time, Mr Buttorff was told in so many words: "I have got problems with it, but I don't want to go back to the old system, other than to see these problems cleared up."

In order to get as unbiased a picture as possible, the study team has not revealed which states were visited or to whom it talked. "The states respect the confidentiality of its clients and we respect the confidentiality of the states," says Mr Buttorff.

The most widely known provision of the act deals with sanctions on public drunkenness. But it also provides a number of major policy directives.

These include creation of non-criminal, treatment-oriented and voluntary approaches to the control and care of alcoholics and intoxicated people. Programs must be fostered by state agencies, meet a minimum standard, and be on a statewide basis.

Services for immediate care, with limited control, of alcohol-impaired people, as well as long term involuntary care if necessary, have also to be provided.

The most publicized intention — moving public inebriates out of the justice system and into the health care system — is, in general, being met.

The report finds: "More money, more time, more knowledge, and more training are all necessary before it becomes a reality everywhere and in all cases.

"The criminal justice system (especially the police) is still involved with public inebriates, but to a much less degree than before, and under circumstances more generally agreeable to all involved.

"There have been considerable savings of police time and resources, and there are excellent prospects for more."

The study finds the act is regarded everywhere as producing these benefits:

- A marked expansion of alcoholism services.
- Greater coordination of alcoholism services statewide.
- Better coordination at the community level.
- More interagency cooperation with state and local governments.
- The creation of services previously inadequate or non-existent.

The report finds these benefits a singularly heavy vote of confidence.

"Coupled with the dramatic decline in numbers of inebriates handled by the criminal justice system, it indicates that the uniform act is causing substantial changes in the delivery of health care services."

This impact has varied. Some health care agencies report success with their program, including improved health care, greater humanitarianism, and a rate of improvement among elements of the public inebriate population higher than has been expected.

Managers of some alcoholism programs complain that too many of the resources are going to the least productive group of alcoholics at the expense of others. Some claim too much of the available money is used on public order, safety, and convenience.

"But all interviewed program managers endorsed the intentions and the current operations of the uniform act as a whole," the report continues.

Eleven state alcoholism authority directors, after lengthy consideration of the report, have decided on several courses of action which will be carried out through the CSTAA.

A major one will be pressure on Congress to change the requirements on funding once a state has decided to pass the uniform act.

The stumbling block is that a state legislature, knowing incentive grant money will be on the way after it adopts the act, is loath to produce enough finance so the program provisions can be met. But until the provisions are met, federal funding does not start.

One way to break this Catch 22 situation, and for which the CSTAA will push, is allowing a one year time lag between enactment and the lifting of criminal sanctions.

At the same time, federal money would be available and the necessary services can be built up ready to meet the needs when sanctions are lifted.

The thorniest problems for the CSTAA to consider, and until now no one has produced more than a hint at the answers, are the inebriate's "voluntary" participation in programs, and the pressure put on police in rural areas about transporting inebriates to and from treatment centres.

Under the act, the state is required to provide treatment services — but alcoholics and inebriates are not required to accept them.

Mr Buttorff elaborates: "There is no problem if the person is incapacitated; he must receive treatment. But when he is not incapacitated, but is intoxicated, a decision has to be made, and most often the people who have to do it are the policemen.

"Treatment directors obviously want to get the people into treatment, take them through a program, and back into society. The law enforcement agencies and the courts want them out of the system as well. But neither are the ones to make the decision.

"What has to be done is to find means by which two rights are preserved: the individual's civil rights, and also his right to get treatment even if he does not know, or want, to exercise that right."

As for transportation, there is no problem in returning a person to his home if he lives in a metropolitan area.

"But, take a rural community which might have a sheriff and his deputy to look after 1,000 square miles. If one or the other takes an inebriate on a half hour trip to a centre, and spends a little time discussing the situation, he may be gone for up to two hours from his community," Mr Buttorff continues.

One possible answer the CSTAA will look at is transport sharing. This could involve, for example, buses which take pupils to schools for special education being made available to handle intoxicated people between 6 pm and 6 am.

An even finer line worries many policemen. Even if the patient is incapacitated when taken for treatment, probably 25 to 50 miles away, he returns to the "voluntary" state when he sobers up. Who then takes him home?

Mr Buttorff points out that the individual policeman may think rightly: "I took him and now he wants back. If I don't go down and get him, what would happen if a civil rights lawyer took his case? I could wind up losing my job and the county sued."

This has not happened yet so there are no answers. However, it has produced one direct effect;

Mr Buttorff again: "As doctors in America now practise defensive medicine, so the people involved in the treatment system and the justice system are having to practise defensively from that point of view."

Fortunately, the report from the CSTAA has highlighted some of the problems. Now action will be taken to find some of the solutions.

The Journal welcomes Letters to the Editor and notifications of Coming Events from its readers. Both letters and Coming Events notices should be sent to: The Journal, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada, M5S 2S1.

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years after their drivers licences have been reinstated. We are interested not only in looking at their Driver Records for evidence of DWI recidivism, but also at the incidence of other criminal offences and subsequent treatment for drinking problems.

Evaluation research takes time, and it will be a while before the long-term impact of the Oshawa DWI course can be assessed properly. We may find it necessary to modify the program to suit better the needs of the second-offender population. Perhaps we may have to extend the course, or have more group discussions. It may be that the program has different effects on different individuals, depending on the severity of their drinking problem. However, the evaluation of the Oshawa DWI program has been designed to answer these questions. Any decisions regarding the Oshawa program will be based on objective evidence as to its effectiveness, and not on blind faith.

Pamela Ennis is a research scientist in the Evaluation Studies department of the Addiction Research Foundation of Ontario.

Around the World

Drug reservoirs

After children who had been accidentally poisoned by household cleaning fluids and non-prescription drugs were released from Brisbane, Australia hospitals, a check on the contents of their family's medicine chests found an extremely high number of varieties of drugs. A total of 702 containers for prescription drugs was found in the 84 households and 650 non-prescription drugs. Among the prescription drugs, antibiotics were most often found, followed by antihistamines, bronchodilators, cough medicines, skin preparations, and analgesics. The commonest non-prescription drugs were analgesics skin preparations and vitamins.

Well-worn slogan

New Zealand's ministry of transport has given up its well-worn "if you drink, don't drive" slogan. In what it considers a more realistic approach in a country where more than half of the road deaths involve alcohol, the ministry will use "alcohol, know your limit" to promote the message.

Death row

A death cell plea for Trinidadian youth not to get involved with marijuana has come from a follower of the late Abdul Malik (Michael X). Stanley Abbott, who has lost his final appeal to the Privy Council, writes in his letter to *The Bomb*, an island newspaper: "Make no mistake about it, marijuana is habit forming. Even that one stick at party-time for thrills is a dangerous venture."

French consumers

The French people's predeliction for drugs has been highlighted in a study which shows that each of the 300 million prescriptions written out last year contained on average three separate medicines. Yet 40% of those prescriptions filled are not consumed by the patients, most of them being thrown away without being opened, according to the study.

Drug probe

Britain consumes a lesser amount of drugs per head of population than most other Western European countries. Britain consumed about $18 worth of drugs per head last year, three times less than the per capita rate recorded by France and West Germany.

Scottish drinking

There might be 250,000 alcoholics in Scotland plus five times that number affected indirectly by alcohol by 1985 if the rate of growth of the disease continues at its present 8% per year. In its 1976 annual report, The Scottish Council on Alcoholism urged the government to reappraise its policies and priorities in providing funds to combat the problem.

UK lung cancer death rate halts 50-year trend

LONDON — Anti-smoking campaigns plus changes in cigarette types are thought to be the major reasons why the death rate from lung cancer in British men has dropped for the first time in 50 years.

However, there is still no success with women smokers and their rate of deaths from lung cancer continues to rise each year, according to the government's Office of Population Census and Surveys.

Overall, deaths from cancer of the lung, bronchus, and trachea dropped to 32,879 in 1975 from 33,057 the previous year. There were 348 fewer male deaths (26,098 from 26,446), but an increase of 170 female deaths (6,781 from 6,611).

The majority of male deaths were in the 65- 74-year-old group, indicating a lifetime of smoking.

The drop in mortality reflects the changes over the last seven years in male smoking habits — a decrease in smoking by family men and those in the professional classes.

The Tobacco Research Council said about 6.5 million men smoked cigarettes in 1975, whereas in 1969 the figure was 7.6 million. However, the number of women smokers has stayed around the nine million mark over the same period.

Keith Bell, secretary of Action on Smoking and Health, a major anti-smoking organization, and a leading physician at London's Central Middlesex Hospital, said he thinks Britain has become the first Western country to register a fall in lung cancer deaths and that the figures "are very encouraging."

He believes the decrease is due to the lowering of tar content in cigarettes over the years, the huge demand for filter cigarettes, and the drop in the total of cigarettes consumed by men.

Dr Bell said the deaths among women, though, leave no room for complacency. "Deaths from lung cancer are still monumentally high and there must be increasing concern for women still unable to give up smoking.

"We still feel much stronger measures must be taken against the tobacco industry."

Education is often educationally unsound

Specialists aren't necessarily right

By Alan Massam

LONDON — Parents and schoolteachers have been urged to avoid over-reliance on "the expert" when planning the education of young people in the problems of drug and alcohol abuse.

J. C. P. Cowley, director of the Teachers' Advisory Council on Alcohol and Drug Education, was stressing at a Royal Society of Health conference here on juvenile drinking that methods used for teaching about addiction were "often *educationally* unsound".

Just as there had been a frantic feeling by teachers that they had to "do something" during the rise of illicit drug use in the mid-60s, concern about the current increase of teenage drinking was producing over-reaction.

"I in no way want to minimize the fact young people today drink in ways that predispose them towards drink problems," Mr Cowley said. "What we may well fear though is that the same mistakes that were made in the 1960s over illicit drugs are now being made concerning alcohol."

Mr Cowley said the illicit drugs of the 1960s were seen as a separate issue, detached from other aspects of life, a new phenomenon of youth, a problem to be dealt with in isolation.

Response to them did not take into account that most people use chemicals throughout life and decisions about these substances could be healthy and helpful or, alternatively, deleterious.

"A fairly simple understanding of adolescent psychology would reveal that if one drug is isolated as pertaining to one age group as alcohol is to teenagers now, then young people will *identify* with the patterns which are being talked about," Mr Cowley said.

"We are then seen as representing a different type of cultural attitude from that of the young person — it becomes an 'us' and 'them' situation."

The speaker claimed a much more satisfactory approach to drug and alcohol education was to discuss the whole spectrum of chemical usage particularly as related to the young person's experience.

This would include talks on how to store substances in the home, how to use the doctor, how to use drugs bought over the counter, and how to deal in the future with opportunities to use illicit drugs.

By a carefully planned approach, young people could be helped to plan their own "chemical career". Thus adults could show that they have to experience exactly the same problems themselves and plan their own way of using chemicals. It removed the "us and them" barrier and helped to keep the subject in perspective.

Mr Cowley said the experience of the mid-60s had shown there was a tendency for an aura to be built up around the subject of substances leading to addiction and for it therefore to be seen as something outside the experience of the teacher.

Everyone, from the police at one extreme to the pro-drug organizations at the other, tried to arrange meetings and publications for teachers suggesting what should be done in schools.

Very few of these "experts" had thought through the educational approach and the consequence was that much of the material reaching children simply publicized drug taking.

"The same thing is still happening, but now it is to do with alcohol," Mr Cowley warned. "Teachers feel they cannot handle the subject, they must have a specialist . ."

The speaker went on to stress that inviting outside "experts" into a school often resulted in educationally harmful practice. It was important to bear in mind that addiction was a long way from the experience of most children. It would be much more useful if teachers could teach about alcohol in the perspective of today's child.

The Teachers' Advisory Council on Alcohol and Drug Education, 2, Mount Street, Manchester M2TNG England, has just produced two pamphlets Teaching your Child About Alcohol, Guidelines for Parents, and Drug, Drugs, Drugs, Basic Facts.

Alcoholism up in UK women

LONDON — Women in Britain are quickly moving towards equality with men in the field of alcoholism.

According to an independent report published Oct. 6, one in three alcoholics in Britain is a woman compared with one in eight in a study compiled in 1966.

The report, by a working party of the National Council of Women, said women are more susceptible to alcoholism than men and have more difficulty in finding help because of the social stigmas.

Drug use provides 'novel stimulus'

PARIS — The fact many different drugs have common behavioral effects may be partly explained by the fact that early experience of taking any drug provides a "novel stimulus".

This suggestion was made by William A. McKim of the department of psychology, Memorial University of Newfoundland, St. John's, to the 21st International Congress of Psychology. •

"When a drug is presented on a small number of occasions, when this stimulus property is still novel, changes in behavior may be a result of both direct effects on brain functioning which alter behavior, and . . . from the fact the animal is now experiencing something different, a novel stimulus."

Dr McKim examined one volume of *Psychopharmacologia* to find out how many times a conclusion was based on the presentation of the drug at a given dosage fewer than three times.

"I found that about 70% of the papers reached conclusions on drug effects produced on less than three occasions."

Dr McKim supported his thesis, which drew favorable comment from other participants, with several arguments.

Firstly, he said, there is strong evidence to support the fact a drug can and does act as a stimulus.

"Indeed it is intuitively apparent that an animal can detect when it is intoxicated and when it is not. It would be surprising indeed if this were shown not to be so."

In addition, said Dr McKim, many drugs, including amphetamines, barbiturates, and scopolamine, have been shown to have rate-dependent effects, that is, to increase behaviors that occur at a low frequency and to decrease behaviors that occur at a high frequency.

He said this rate-dependent effect is quite similar to the effect of a novel stimulus on fixed interval behavior and on the delayed reinforcement paradigm of Pavlov.

Comic books carry the anti-alcohol message

Hotshot Angel takes on Sludger

LONDON — British kids are being introduced to "Slimy Sludger — one of the worst Demons of Alcohol" in a new bid to keep them on the straight and narrow track of total abstinence.

Slimy is the creation of a leading temperance organization, the Band of Hope Union, which features him in a new picture paper for distribution to schools for 7-to-11-year-olds.

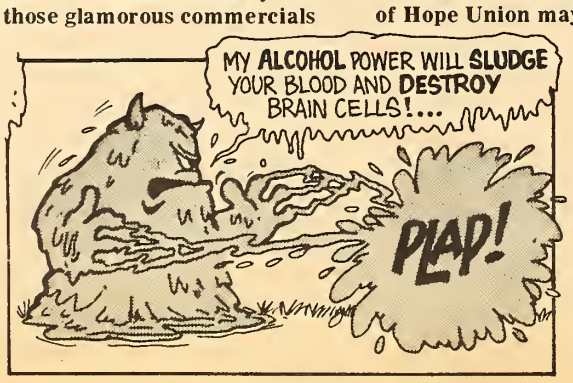
The Sludger meets his match in a zippy little angel called Hotshot who in later editions will prove his superior powers against drugs, tobacco, and school bullies.

Slimy Sludger and Hotshot the Angel are the creation of cartoonist John Pickering and writer Glynis White who say they want to eliminate the desire to drink created by "all those glamorous commercials on television".

Whether Hotshot will prove to be too goody goody for the average 10-year-old, however, remains to be seen. The Band of Hope Union may find suffering Sludger wins some sympathy.

* * *

The Band of Hope Union, 45 Great Peter Street, London SW1P 3LT (Tel: 01-222-6809)



The 'Sludger'

'Hotshot'

Teenage drinker witch hunts must be avoided, says UK

By Alan Massam

LONDON — A small population survey into the drinking habits of British young people has confirmed the fears of field workers that alcohol abuse is starting earlier.

But the response to this latest set of observations on teeny boozers, as they have come to be known, has been uneasiness about the way the problem is being tackled.

Sir Dick Caldwell, director of the Medical Council on Alcoholism, for example, says he would resist any suggestion of a public campaign aimed at the young which might be counter productive.

Sir Dick says his council is growing increasingly concerned about teenage drinkers, but is anxious to avoid helping to create a public myth that drink is a special problem of the young.

"There are all kinds of signs indicating an increase in drinking in the young which appears to be a global phenomenom, but we do not know to what extent it merely reflects the increase in drinking throughout our society," he says.

"There is a lack of hard data. We are trying to establish from the youth clubs and the schools what the situation really is and the best method of tackling it. We feel teachers and parents may be the best people to handle the problem given the right help and information."

Sir Dick was clearly anxious to avoid sensational media treatment for the latest population survey.

The survey was conducted by the Coventry and Warwickshire Council on Alcoholism and came up with the conclusion that 65% of British youngsters in the 11 to 13 age group have sampled alcoholic beverages and 56% of males and 36% of females in that age group drink alcohol between one and three times a week.

The survey, which covered the drinking habits of 1,239 young people (aged between 11 and 21) in Coventry, found that in the 11-13 age group 64.2% of males and 40% of females suggested they were "more than occasional or seasonal drinkers".

In the 14-17 age group, 11.2% of males and 9.8% of females said they drank from four to seven times a week while in the 18-21 age group 70.7% of males and 36.9% of females claimed that frequency.

Executive director of the Coventry and Warwickshire Council on Alcoholism, John Charnley, said the youngsters surveyed were asked whether after drinking they had ever experienced loss of memory; whether they had taken drink before or during breakfast; had become drunk while alone; had experienced aggressive behavior because of drinking; or were spending most of their money on drink.

Abuse, he said, was considered to be indicated if any two of these factors were present. The survey showed that in the 11-13 age group, 5% of the male "current drinkers" fulfilled the criteria of abuse (a total of three boys in the whole sample.) No girls this young were found to have reached the "abuse" stage.

Among the 14-to-17-year-olds there were 44 males (20.1%) and 22 females (9.9%) who gave evidence of abuse. In the 18 to 21 age group there were 95 males (41.5%) and 23 females (14.7%) who gave evidence of abuse.

Mr Charnley says: "Basically, there are three reasons why anyone starts to consume alcoholic beverages — curiosity, custom, and conviviality. However, attitudes and availability play a significant part in determining reasons for drinking, and I am more concerned with the negative reasons, like 'nothing else to do' or 'because I need to'."

He says the results of survey show the need for further studies and the need to review the whole question of health education, social activities, and the treatment and care of those youngsters who present alcohol abuse problems.

"We were not carrying out a teenage witch hunt. Far too much emphasis is being placed on teenage drinking, rather than on the evidence of those who are at high risk by abusing alcohol. We want to find ways of helping teenage drinkers to enjoy a pleasant social pastime without the risk of attendant problems in later life," he says.

Amsterdam is unchallenged heroin capital

Dutch fight a 'disastrous reputation'

By Thomas Land

AMSTERDAM — An International gang of heroin merchants involved with the so-called 'Chinese Connection' has been smashed in Holland after the arrest of a Canadian, aged 51 and identified by police only by his initials. He was detained at Schiphol Airport just before boarding a flight to Canada.

He was reported to be carrying 300 grams of pure heroin, worth between 15,000 and 20,000 guilders (or up to $8,000) on the Amsterdam market. The consignment would have fetched far more than that in Canada or the United States.

After his arrest, an undisclosed number of Dutchmen were also detained. The operation is part of a concentrated drive to free Amsterdam of its disastrous reputation as the unchallenged heroin capital of Europe.

Earlier, 38 members of another gang of heroin dealer were arrested in police raids in four southeastern cities. A police spokesman said they had sold at least 40 kilos of heroin to addicts in Einhoven, Nijmegen, Den Bosch and Unden.

The leader of the group, was Chinese and at least two of the Dutch members had been used as couriers to bring drugs from the Far East, destined for the desperate black markets of Holland and neighboring countries, especially prosperous West Germany. Police believe the trade is controlled by Chinese gangs from the Far East, particularly Singapore, Bangkok, and Kuala Lumpur.

Dutch police operations herald a tightening of attitudes by the law enforcement authorities here. Holland's neighbors have been concerned for some time by the remarkably relaxed approach taken by the Dutch to drug abuse and related crimes. For there is evidence that the tolerance of the Dutch has enabled big business profiting from drug addiction to establish a relatively secure new European base here.

In the past two years, a ruthless and carefully organized network of Chinese heroin traders has taken over the markets of the notorious French Connection after its destruction through the cooperation of North American and West European narcotics agents.

A Chinese courier, who has guarded his cargo all the way from the heroin refineries of Hong Kong, exchanges his goods for cash in the crowded streets of Amsterdam.

As a result, burglaries of pharmacies by drug-starved addicts, until recently common in West Germany and France, have come to an end. Black market heroin prices have also dropped, despite inflation.

Large-scale drug addiction, until recently associated in the West mainly with North America, is thus appearing in the prosperous cities of the European Community.

Holland alone is thought to have a population of up to 30,000 heroin users, followed by West Germany with 15,000 addicts. France is believed to have 5,000 to 6,000 addicts and Belgium and Britain about 3,000 each. About 1,000 Europeans were expected to die by heroin during 1976.

The bulk of Europe's heroin seizures is being made in Holland, evidently the major transit point of the trade. The operations have largely switched from Asian to European carriers, and individual consignments have been increased in size and value.

One new product on the black market is the virtually pure "Chinese Number Four" heroin, which is thought to be the cause of many fatalities.

The trade originates from the Golden Triangle of Burma, Laos, and Thailand which produces a crop of up to 700 tons of opium a year. Specialists believe the entire operation can be brought under control only through a vast cooperative undertaking embracing all the countries involved — and especially those three.

Glue/solvent sniffing on the increase in Britain

Thousands of children may now be experimenting

LONDON — Glue or solvent sniffing, although still only a small problem in the United Kingdom, is definitely on the increase.

This has been reported by Dr Joyce Watson, senior registrar in community medicine for the Greater Glasgow Health Board.

Dr Watson says the number of children and young people involved in "sniffing" is increasing every year in the West of Scotland and elsewhere.

"Current estimations indicate the possibility that thousands of youngsters may now be experimenting with solvents," she says in *Nursing Mirror*.

"Actual figures are hard to find, but almost 250 cases came to our attention last year in Lanarkshire (the Scottish county) alone."

Dr Watson reports that many British children are unaware that sniffing can damage their health or, among those that are, that some inhaled substances can bo more harmful than glue.

However, despite the number of sniffers, only a few have needed hospital treatment. Those admitted to hospital in Glasgow had suffered liver or kidney damage, but it was reversible.

Twelve sniffing-associated deaths have occurred in Scotland since 1970, five since May 1975, and in England the total was "perhaps twice this number".

"It is not only the habitual or chronic sniffers who are dicing with death, but also the sporadic users," Dr Watson warns.

NZ attitudes unchanged by ad campaign

AUCKLAND, NZ — A Ministry of Transport publicity campaign in 1975 reached the majority of New Zealanders but achieved "almost no significant change" in public attitudes towards drinking and driving, a survey has shown.

The campaign tried to persuade the 15-24 age group that there is an alternative to drinking and driving. But, of those who were aware of radio and newspaper publicity, only 28% said that at least once they were influenced to drink less before driving, and 10% were influenced, at least once, not to drive after drinking.

Comparable figures for those who saw a television film were 29% and 13% respectively.

New Zealand votes for 'family lounges' in pubs

AUCKLAND — In a major social change for New Zealand, children of any age will in future be permitted to drink alcohol with their parents in special "family lounge bars".

Yet, Parliament has rejected a proposal to lower the legal drinking age to 18 and voted instead to allow 18- and 19-year-olds to drink on licensed premises only if they are accompanied by a spouse (aged 20 or more) or by a parent.

A late amendment to new liquor legislation, now passed through Parliament, will allow hotel keepers to apply to a magistrate for parts of their premises to be designated family lounge bars.

In these areas, and within specified hours, children will be allowed to drink alcohol — but not buy it — provided they are accompanied by a parent aged 20 or more.

The magistrate may make the provision of food, non-alcoholic drinks, or entertainment a condition of such a permit.

"The main purpose is to change social attitudes which can only be done by allowing families to visit hotels as a family," said Richard F. Walls, the government member of Parliament who proposed the innovation.

The new law should end a situation that has led the justice department to observe that "contempt for the law is accentuated by the creation of inherently absurd situations as, for example, the exclusion of an adult couple with a baby in a pram from a beer garden".

It also follows a recommendation of a 1974 royal commission on liquor, which commented: "Where the conditions are right, we do not see why a child should not visit a public house or any other form of licensed premises with a bar in the company of his family. It is better in our views that they should come to see drinking in the right conditions as simply an incidental part of normal social activity...."

A lower drinking age was supported by the minister of justice, David S. Thomson, who said police last year found 4,592 people aged 18-20 drinking on licensed premises and this was probably only "the tip of the iceberg".

The National Society on Alcoholism and Drug Dependence also favored a lower age, saying the present limit of 20 is largely unenforceable (**The Journal**, Aug. 1, 1976).

But 74% of those questioned in a national opinion poll opposed lowering the age. Even 59% of those aged 15-24 supported the present law.

A spokesman for the Salvation Army, which organized a national petition opposing a lower age, called the concession for those accompanied by an older spouse or parent "a devious way of gaining a point".

Implicit in the Parliamentary debate was the assumption that the age will probably be lowered to 18, the minimum which applied before 1910, some time in the future. The matter will probably be left for a new alcoholic liquor advisory council, which will be set up by legislation now before Parliament, to recommend when it believes the time is ripe.

The new legislation also lifts a 1917 restriction prohibiting diners from drinking their own alcohol in an unlicensed restaurant after 6 pm.

And it provides for permits allowing hotel and tavern bars to remain open on Fridays, Saturdays, and Christmas Eve until 11 pm (one hour later than on other nights) and on New Year's Day until 12.30 am.

Another change — obviously intended to legalize present illegal practices — will allow sporting clubs and social or cultural organizations to obtain liquor licences for their premises.

Patients disobey orders

QUEBEC CITY — Psychiatric patients aren't following doctors' orders when it comes to maintaining their prescribed drug regimens — in or out of hospital.

"The high recidivism rate for patients who have discontinued their maintenance anti-psychotic medications is becoming a major public health problem in the world," John J. Schwab, chairman of the department of psychiatry, University of Louisville, told a meeting of the Collegium Internationale Neuro-Psychopharmacologicum, held here.

A University of Louisville study Dr Schwab quoted, looked at differentials regarding sex, age, and social class with respect to usage of both licit and illicit drugs. The sample consisted of 1,645 adults between the ages of 17 and 92 years.

A major finding was the differing socio-demographic patterns associated with the use of various drugs and alcohol. Licit drug usage was related to emotional distress, while illicit drug usage was found to be largely a youthful cultural phenomenon.

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CUT THIS ONE AND MAIL

New Books

by RON HALL

The Adventure of Sobriety

. . . by David A. Stewart

In this book, the author proposes reasons for drinking and classifies the meaning of drinking habits under the headings: intention, techniques, and outcome. Problem drinking begins with good intentions that become defective and lead to the five stages of the drinking pattern. Attack treatments which are based on modifications, cure, or control, shift the control out of the "self" to the care of experts and are generally nonemphathetic. The moral model is ego-oriented and is a process governed by self-will. The five steps to freedom from alcoholism are outlined and the Alcoholics Anonymous way of life is vigorously supported.

(Michigan State University Press, 1405 South Harrison Road, East Lansing, Michigan, 48824. 1976. 142p. $7.50.

Pharmacology of Marihuana

. . . edited by Monique C. Braude and Stephen Szara

This two-volume set of papers, presented at a National Institute on Drug Abuse-sponsored conference in 1974, presents a discussion of the pharmacology of marijuana under various topical headings including: chemical and metabolic aspects, cellular, immunological, and hormonal effects, autonomical effects, neuropharmacological effects, behavioral pharmacology and interactions, and genetic and reproductive aspects. The materials presented provide the reader with the opportunity of reviewing this topic in detail.

(Raven Press, 1140 Avenue of the Americas, New York, 10036. 1976. 901p. $50.)

Other Books

Alcohol Dependence — Boston Globe Medical Department, Boston, 1976. "Boston Globe alcohol recovery program, 23 questions and answers on the nature of alcohol dependence." 20 p.

Cross-Cultural Approaches to the Study of Alcohol: An Interdisciplinary Perspective — Everett, Michael W., Waddell, Jack O., and Heath, Dwight B (eds). Mouton Publishers, The Hague, 1976. Ethnographic studies, physiological and biomedical aspects, cross-cultural theories, methodology, indices. 432p. $28.65.

Task Force 11 Report on the Operation and Effectiveness of the Ontario Detoxication System — Annis, Helen, Geisbrecht, Norman, Ogborne, Alan, and Smart, Reginald. Addiction Research Foundation, Toronto, 1976. Methods of handling drunkenness offenders, objectives of detoxication-halfway house programs, characteristics of admissions, arrests, physical health, recommendations, references. 63p. $2.50.

The Effects of Centrally Active Drugs on Voluntary Alcohol consumption — Sinclair, J. D., and Kiianmaa, K. (eds). Finnish Foundation for Alcohol Studies, Volume 24, 1975. Satellite Symposium to the Sixth International Congress of Pharmacology, held July 26, 1975 in Helsinki. 161p. $7.

Stress in Health and Disease — Selye, Hans. Butterworth Group, Toronto, 1976. Stress concept, stressors and conditioning agents, manifestations of stress, diseases of adaptation, treatment, theories, indices, 1256p.

The Complete Handbook of Ginseng — Heffern, Richard. Celestial Arts, Millbrae, 1976. Botany, history, use, research, cultivation and marketing. 128p.

Management's Approach to Alcoholism — Moore, Guy Phillips. Jones Publishing Co., Asheville, 1975. Industrial programs, program development, literature review, programming model, evaluation. 103p.

Alcoholism — Silverstein, Alvin, and Silverstein, Virginia, B. J. B. Lippincott Co., Philadelphia, 1975. Beverages, effects on the body, history, social and problem drinking, drinking and driving, teenage drinking and treatment. 128p.

The Incidence of Drugs in Fatally Injured Drivers — Woodhouse, E. J. National Technical Information Service, Springfield, 1974. Research, experimental procedures and results, analysis, conclusions. 130p.

Proceedings: Seminar on Alcoholism Emergency Care Services Action Against Alcohol Problems — New York State Task Force on Alcohol Problems, New York, 1975. Report of the statewide planning effort on alcohol problems 1972-75.

Marijuana: Chemistry, Biochemistry and Cellular Effects — Nahas, Gabriel G., Patton, William D.M. and Idanpaan-Heikkila, Juhana E. Springer-Verlag, New York, 1976. Proceedings of the Satellite Symposium on Marijuana of the Sixth International Congress of Pharmacology held July 26-27, 1975, in Helsinki. 556p.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Detox Workers Training Program — Feb 7-11 and March 7-11, 1977, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, 33 Russell St, Toronto, Ont, M5S 2S1.

Health Research Ontario — March 4-5, 1977, Toronto, Ontario. Information: Bill Gilliland, Addiction Research Foundation of Ontario, 33 Russell St, Toronto, Ont, M5S 2S1.

1st International Congress on Toxicology — March 30-April 2, 1977, Toronto, Ontario. Information: Robert G. Burford, G. D. Searle and Company of Canada Ltd, 400 Iroquois Shore Rd, Oakville, Ontario.

INPUT 77: 2nd National Conference on Occupational Alcoholism and Drug Abuse — May 1-4, 1977, Ottawa, Ontario. Information: Phyllis Buirds, Humber College, Conferences and Seminars, Centre for Continuous Learning, PO Box 1900, Rexdale, Ontario, M9W 5L7.

The Canadian Medical Association and Quebec Division annual meeting — June 19-24, 1977, Quebec City, Quebec.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections 1977, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies annual conference FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

2nd World Conference of Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference Headquarters, c/o The Portage Institute, 3418 Drummond St, Montreal, Quebec.

US

National Clergy Council on Alcoholism — Jan 10-14, 1977, Los Angeles, California. Information: Rev John P. Cunningham, executive director, NCCA, 2749 North Marshfield Ave, Chicago Illinois, 60614.

3rd Annual Research Meeting: Alcoholism — The Search for the Sources — Jan 26-28, 1977, Research Triangle Park, North Carolina. Information: Center for Alcohol Studies, Medical Building 207-H, Chapel Hill, NC, 27514.

2nd National Conference on the Impaired Physician — Feb. 4-6, 1977, Atlanta, Georgia. Information: Department of Mental Health, American Medical Association, 535 N. Dearborn St, Chicago, Illinois, 60610.

American Society for Pharmacology and Therapeutics — March 24-25, 1977, Dallas, Texas. Information: American Society for Clinical Pharmacology and Therapeutics, 1718 Gallagher Rd, Norristown, Pennsylvania, 19401.

National Council on Alcoholism/American Medical Society on Alcoholism 8th Annual Medical-Scientific Meeting — San Diego, California. Information: Frank A. Seixas, National Council on Alcoholism, 733 Third Ave, New York, NY, 10017.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC — 1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Center, McLean Hospital, 115 Mill St, Belmont, Massachusetts, 02178.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, Arizona, 85010.

Abroad

7th International Conference on Alcohol, Drugs and Traffic Safety — Jan 23-28, 1977, Melbourne, Australia. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Cruising Medical Seminar on Alcoholism — Feb 26-March 5, 1977, Carribean cruise aboard Cunard Countess. Information: Center for Alcohol Studies, Medical Building, 207-H, Chapel Hill, North Carolina, 27514.

6th International Conference of the World Union of Organizations for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28 Place Saint-Georges, F-75442, Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic, Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

7th International Institute on the Prevention and Treatment of Drug Dependence — June 13-15, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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'Protecting the Pint'

Big brewers bashed by British beer lovers

By Harvey McConnell

LONDON — Young's Special, Ruddle's County, Harvey's Elizabethan, Gales' Horndean, Theakston's Old Peculier, King and Barnes' Wealden, Brickwood's Best, Fuller's ESB.

Four years ago, these were among the beers produced by small regional breweries in Britain that were sold only in their own pubs and hardly known outside their geographic area.

They are cheap, tasty, bitter beers drawn from barrels, each with a distinctive flavor — for centuries the aqua vita of the common man.

Today, the names roll off the tongues of tens of thousands of beer drinkers, often with the reverence reserved for the classic growths of Burgundy or Bordeaux. Demand far outstrips production.

During the same four years, the Big Six combines that evolved over the past 20 years — Watney Man, Courage, Whitbread, Bass Charrington, Scottish and Newcastle, and Allied Breweries — and which produce most of the beer and own most pubs, have seen millions of dollars in advertising wasted, profits stagnate and, worst of all, their corporate names attract extreme odium.

THE BACK PAGE

The Big Six are the cause, and victim, of the most successful consumer revolt ever seen in any country. Paradoxically, the revolution has lead to an overall increase in beer consumption, especially among young people.

The change is due to the Campaign for Real Ale (CAMRA) and columnist Richard Boston of The Guardian newspaper.

A century ago, Britain had some 16,000 companies brewing beer. Today it has less than 100. Beer consumption started to slide in the 1950s as television emptied the pubs and inexpensive wine became voguish.

Brewery amalgamation accelerated and in the 1960s the takeovers and mergers during the frantic race for conglomerate growth, emerged. Business school cliches ruled.

Central control and brewing, expensive and aggressive marketing, took pride of place.

The quality of the beer came last.

Month by month, as they took over, the Big Six closed down small brewery production of what is now called "real beer" — draught beer that is a living brew when it is pulled by pressure from barrel into glass.

Each barrel is biologically alive when it reaches the pub and has to be allowed two or three days for sediment to settle. When air is admitted through a small hole, a secondary fermentation takes place and this produces a natural foam head.

This cask-condition beer, as it is called in the trade, has to be consumed within a few weeks. Hot weather, or uncaring pub staff, can lead to the drawing of a vile pint.

While the independent breweries continued to produce cask-condition beer, the Big Six decided on a radical change: keg beer. This beer is made in the normal manner but then it is filtered and pasteurized — rendering it biologically dead — put into barrels, and served via a blanket of carbon dioxide gas pressure.

The Big Six like keg beer because it will keep for months, does not need to settle, and each pint is like the last. But keg beer is a bland, gassy flavorless brew.

At the same time, the Big Six attacked their pubs with massive "modernization". Many beautiful mirrored and mahogany-clad Victorian interiors were ripped from a place in history and garish plastic substituted. Some pubs that had hardly changed in 150 years were gutted.

Millions of dollars were also spent in massive television and press campaigns for Watney's Red, Courage's Tavern, Whitbread's Trophy, Allied's Double Diamond, Younger's Tartan, and Bass Charrington's Worthington E. Keg beer arrived with a vengeance and customers had no choice when they wanted draught beer: it was keg or nothing.

Against this background, Richard Boston in 1973 started his Saturday column in The Guardian. Boston on Beer became, literally, an overnight success.

In his just published book, *Beer and Skittles*, a fascinating history of beer and pubs, Mr Boston recalls what happened.

Reader interest was greater than expected and letters poured in full of suggestions, information, appreciation, and encouragement. There was nothing like it around.

Mr Boston says: "I was able to collect and pass on information about breweries that were still producing traditional beer (mostly the surviving independent regional breweries), to attack what the big companies were doing to beer and pubs, and generally write about the subject in a way appropriate to what is, after all, a major part of the nation's leisure activities."

A consumer organization was needed and it arrived with CAMRA, which was started as a small protest group in Manchester and numbered several journalists among the founders. The "ale" in the title is misleading to some extent — it was used instead of beer to give more panache to the movement.

Mr Boston again: "I think that three years ago, the most anyone hoped for was that our protests and derision might, even if ever so slightly, slow down what the big bad brewers were doing to beer and pubs.

"Within two years, it was apparent not only that this was happening, but also that the brewers were actually changing tack and reversing previous policies.

"The consumer revolt against the big brewers that has taken place in the past three or four years is unique. I know of no other industry of this size that has been checked in the direction it has taken by the massive resistance of the customers.

"This is gratifying to the beer drinkers, but the achievement is one that is important to others as well. It has demonstrated that we need not be endlessly manipulated by the forces of the state or big business."

The impact of CAMRA protests — demontrations when a brewery was closed down, continual press campaigns — generated bitter resentment among the Big Six, and much of it remains. At first the big brewers tried to ignore CAMRA, and then turned to ridicule.

The parrot cry was that the big brewers were selling what the customer wanted. The fact that the customer had no say, or choice, was brushed aside.

Membership of CAMRA rocketed from 2,000 in the first year to over 30,000 now. Members pay a yearly £4 membership, receive a monthly newspaper, What's Brewing, and join any one of 100-odd branches.

Most of the founder members are now full time paid CAMRA officials. Success has spawned CAMRA Investments, a separate public company which owns and operates five real beer pubs around the country, and all show a healthy profit.

What's Brewing leads the monthly CAMRA fight. The latest issue, for example, continues to challenge the monopoly hold the Big Six have on pubs in many areas. It records that in Kirkgate, for example, a small town in Nottinghamshire, Courage has led a so-far successful fight, with its pub managers in the forefront, to stop a real beer pub from opening.

But, above all, CAMRA publishes a Real Beer Guide which to drinkers is what the Michelin guide is to the lover of good food. It lists pubs which serve real beer and where to find them.

Many of the branches also publish a local guide and include many pubs, which for reasons of space, cannot appear in the national guide.

Like all really successful movements, CAMRA's strength is at the grassroots. One of the most active is the Brighton and South Down branch in Sussex, which also has one of the biggest local memberships.

The Brighton branch also demonstrates the diverse backgrounds of the real beer lovers. Lawyer Nick Hall, John Taylor, a post office employee, Tony Roberts, a college engineering teacher, biochemist Geoff Pickering, are some of the leaders. And in Frank Butler they have an unpaid Treasuer who has put a healthy black ledger in the bank.

Brighton, 50 miles from London is typical. Of the 289 pubs in the town, all but 31 are controlled by the Big Six. Watney's are the major holder with 102 pubs.

Yet, seven miles away, in Lewes, Harvey's produces its beer in a 150-year-old brewery, and 15 miles away, in Horsham, King and Barnes does the same. But until CAMRA started campaigning, not a drop of real beer was to be found in Brighton.

Today, King and Barnes, and Harvey's have 20-odd outlets in Brighton and would be able to sell more, if they could produce it.

One widely sought brand of real beer that is not found in Brighton, or most other areas, is brewed by Young's of London.

Young's is the perfect small brewery that the big business executive will tell you won't work. But it has, and does, famously.

Chairman John Young says: "Demand for Young's beer is so staggering that we have not been able to take on any new accounts for over a year." Despite the economic portents in Britain, the company is investing a large sum to boost production by 25%.

In its last financial year profits trebled to more than $10m.

Although it owns only 150 pubs among the thousands in London, and most are in one suburban area, readers of the London Evening Standard have four times in the last six years voted a Young's house Pub of the Year.

Young's is unique. Not only does it still have beam engines dated 1835 working as efficiently as ever, it also keeps on employees past retirement age, and in the brewery yard it boasts a mascot ram, geese, and turkeys, and 27 magnificent shire horses.

Every day, teams of horses leave the brewery loaded with beer. It is economics, and not sentiment alone, that keeps them: horses delivering 10,000 tons of beer a week to 40 pubs within a three mile radius are more efficient than trucks.

Every Friday, retired employees show up to collect their company pension and pass a few hours in the beer sampling room. Mr Young's great grandmother is the company's oldest stockholder: in November she was 106.

A few miles away, housed in East End buildings that date from the 17th century, are the headquarters of Watney Mann, which has probably suffered more than any of the other Big Six breweries from the CAMRA campaign.

The name Watney has become the symbol of what is bad in brewing.

Matters became so serious that there has been a major management reshuffle and the combines has been split into regional companies which now make all the brewing decisions.

The changes extended even to repainting the exteriors of the pubs, which had been a uniform red. Now most boast a decor in varying shades of anything but red.

Paul Walmsley, who was drafted two years ago as public relations director, thinks the rot has stopped and the company is gaining ground.

He points to the factor that hurt Watney's most of all: "Unfortunately, while we are only the fourth largest of the big breweries, the majority of our pubs are in London and southeast England. Consequently most everybody, especially the newspapers, thought that Watney's control everything."

He agrees the previous management made two big mistakes: fighting CAMRA tooth and nail, at first, and launching Watney's Red, the keg beer that backfired.

Watney's, like others in the Big Six, has recently launched a real beer called fined bitter. It has been so successful in 125 London pubs that the Midlands region has decided to put it into more than 100 pubs in its area.

Fortunately for Watney's, it allowed some small breweries it had bought out to continue to make real beer. Others in the Big Six, like Courage's, which was on the point of killing off its director's bitter, is now feverishly promoting it.

Where CAMRA goes from here is an intriguing question. It is trying to keep up its membership and fight the lurking fear in that having achieved so much, members will now feel the fight is won and they need no longer belong.

Unfortunately, the movement sometimes takes itself too seriously, as Mr Boston has found.

"It is often too doctrinaire and at times shows signs of confusing beer with religion. In fairness, CAMRA has usually been quick to face up to its own faults and do something about them."

The movement has also spawned its share of Beer Bores, who seem intent on outdoing the wine snob. Endless discussion on how dry hopped the Bass is these days, or whether a pint with a light cloudy haze is drinkable, can become wearing.

CAMRA success has also brought in the ripoff artists — pubs that charge ridiculous prices, or wine bars that have gone into selling real ale at inflated sums. Neither will make the good beer guides.

What it comes down to is put succinctly by Tony Roberts in Brighton:

"All we want is a bloody good pint of beer, served at a reasonable price and in reasonable surroundings.' "

The Journal

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Canada protesting US poppy plan

By Anne MacLennan

OTTAWA — Canada has sent a diplomatic note to the United States protesting the US decision to authorize commercial cultivation of the scarlet poppy — *Papaver bracteatum*.

The decision, reached after lengthy deliberation and pressure and with keen support from pharmaceutical manufacturers and doctors, was revealed last month in **The Journal** (January).

It means, in effect, that America has issued itself a licence to grow its own codeine. (The scarlet poppy yields thebaine which in turn can be used to make several narcotic drugs, particularly codeine. Most codeine currently is processed from the opium poppy, *Papaver somniferum*.)

Although the contents of the note are confidential, Canada's protest unquestionably centres on the fact the United States is acting apparently without regard for the potentially serious international implications of its decision, particularly in countries now growing opium poppies, but with a spillover effect in many other countries.

Don Smith is senior scientist, International Health Office, Health and Welfare, Canada, and head of Canada's delegation to the United Nations Commission on Narcotic Drugs which meets this month in Geneva.

In an interview with **The Journal**, Dr Smith referred to the broader view of Canada's position contained in this country's working paper on licit trade in opiates, which will be presented at the Geneva meeting.

"Canada has been a strong supporter of the efforts of the United Nations Commission over the years which have been directed towards reducing the number of countries engaged in growing the poppy for opiate production, particularly on a large scale for the international licit trade, because of the expense and difficulties in maintaining effective surveillance and enforcement measures.

"It would be regrettable if

(See — Canadians — Page 6)

Life in the primitive mountain villages of the Golden Triangle revolves around families and opium fields. Anne MacLennan examines the way the lives of the simple tribespeople touch the lives of North Americans.

Opium producers will get US aid

By Harvey McConnell

WASHINGTON — Peter Bourne, whom President Jimmy Carter has just appointed special assistant for mental health and drug abuse, says a significant shift in American policy towards countries where opium is grown will be made by the President.

Dr Bourne said in an exclusive interview with **The Journal**: "It is important the United States play a role in the social development in these countries and not look at it in narrow terms of getting rid of the opium poppy, and stopping heroin getting to the United States."

At the same time, however, Dr Bourne warned that other nations must not look to the United States to shoulder the whole burden, particularly in the United Nations.

Dr Bourne said: "It is a question of looking at the things that

(See — Enforcement — Page 7)

BC's ardor cools for Japanese plan

By Tim Padmore

VANCOUVER — After a first-hand look at Japan's system of compulsory treatment for heroin addicts, British Columbia health minister Bob McClelland has lost his enthusiasm for implementing a similar system here.

Mr McClelland, who earlier in the fall had indicated he hoped to introduce legislation that would make addiction illegal and require addicts to accept treatment, has told **The Journal** that the trip "raised more questions in my own mind than I got answers".

Compulsory treatment, which he praised in an address to the BC Corrections Association in October, is, he now says, only "one system we're looking at, with others".

The minister spent a week in Japan in late November touring Japanese drug treatment facilities with Bert Hoskin, chairman of the BC Alcohol and Drug Commission and an advocate of compulsory treatment.

The Japanese program, said Mr McClelland, is tremendously successful but part of the success can be attributed to cultural factors.

The Japanese have a different attitude to life and to their government.

"They're a very law-abiding people for one thing. . . The people in the community, the families of addicts, are willing to identify addicts to the authorities.

"And the kind of addicts they had, seemed to be willing to put themselves forward for voluntary treatment rather than go into the criminal system," he added, noting that only about 10% of the addicts identified had to be forced to accept treatment.

Many addicts apparently quit on their own, he said, rather than risk the stigma of becoming involved with the law.

Another factor is the scale of the problem here.

"Our drug problem is much more serious. At the peak, there were an estimated 40,000 addicts in Japan, which has a population of something like 100 million. We have estimated there may be 10,000 in BC, with a population of 2 million. And they don't have the same criminal involvement.

"The problem is not the same, so the solution may not be the same."

However Mr McClelland did say he thought the counselling and follow-up parts of the Japanese program could be transplanted to BC.

The Japanese system provides for up to six months of compulsory hospitalization (average stay is 41 days), followed by counselling and a five-year follow-up.

The health minister said an interdepartmental advisory committee is currently working on recommendations for restructuring the province's approach to drug addiction and he hopes to have a legislative package ready by spring.

'Alcohol's the problem—not commercials'

Broadcasters enter ad fray

By Bryne Carruthers

OTTAWA — The Canadian Association of Broadcasters (CAB) has taken a swipe at proposals by federal health minister Marc Lalonde to eliminate "lifestyle" beer commercials on television, to restrict broadcasting times for beer and wine advertising, and to require a health warning on the broadcasters' advertising.

In a submission entitled Alcoholism is the problem, not broadcast beer commercials, the broadcasters' association maintains that even the heavily criticized beer commercials (which show young, sexy, hip couples, drinking beer with gusto during and after sport and social activities) don't promote excessive drinking.

The principal purpose of the advertisements is merely to influence brand selection, the CAB says.

The commercials show no more than one glass per person "in a health environment which reflects a setting not unlike many real life social gatherings," the association notes.

One newspaper columnist was quick to point out the commercials promote beer by showing how "in" and how enjoyable life can be for those who drink beer. And it is obvious the advertised social gatherings won't end after the one beer is consumed.

In fact, some commercials show a 24-bottle case or two of beer being brought to a cottage for what is obviously going to be a wild and woolly weekend.

The CAB says restricting the hours that beer and wine advertising could be aired on television could cause problems in coast-to-

(See — Broadcasters — Page 6)

A 20-year study of the smoking habits and health records of British doctors suggests about one third to one half of all cigarette smokers will die because of the habit. See page 7.

Andrew Weil would like to see coca leaves used first as a therapeutic drug and, after that, as a recreational drug. See The Back Page.

Regular features

US has more press freedom than Canada: High Times ed.

TORONTO — A little-used Canadian law which has prohibited certain issues of *High Times* magazine from being distributed in Canada has made publisher Andrew Kowal realize the "freedom of the press" he enjoys in the United States.

The January issue of the consumer magazine which is devoted to coverage of the cultivation and consumption of "recreational drugs" was stopped at the border by the Customs and Excise Branch of Revenue Canada under Section 422 of the Criminal Code. It states it is an offence to "counsel, procure or incite" anyone to commit a criminal act.

This is believed to be the first time the Canadian government has moved to stop a magazine from coming into the country on grounds other than that it is pornographic — and it has some legal experts worried.

Edward Greenspan, a prominent Canadian criminal lawyer, has said that particular section of the Criminal Code should have never been used to stop the magazine as it does not apply.

"I don't think the Criminal Code was ever intended to infringe on the freedom of the press, except in specific instances of contempt of court. It is insidious that it should be used as a form of harassment," Mr Greenspan told a Canadian daily newspaper.

Although the US Drug Enforcement Administration scrutinizes each issue of *High Times*, it has not clamped down on the magazine, and Mr Kowal believes the censorship which has been applied in Canada to his magazine on a "now and again" basis could not happen in his own country.

Acting independently of federal officials and other provincial authorities, Ontario's Attorney General, Roy McMurty, ordered an investigation into the magazine in November, 1976. Ontario Provincial Police, armed with search warrants, and employing Section 422, confiscated copies of *High Times* from local distributors.

Mr Kowal told the Washington conference of the National Organization for the Reform of Marijuana Laws: "Generally we have not had trouble with the (US) law that we are aware of. It is really amazing to me, and a lot of our associated ex-radicals, that this country actually lets us exist and print the way we do."

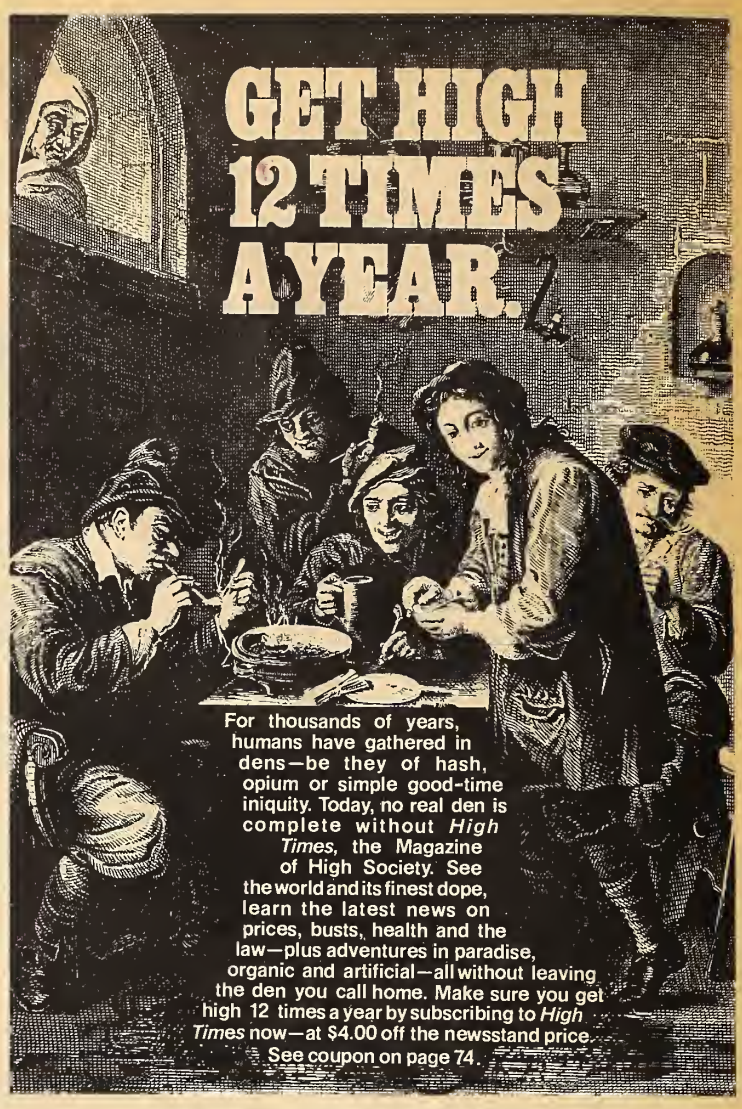
"We like to believe that *High Times* discusses things other than drugs — although we will certainly not deny it was because of our discussion of dope that brought out our popularity from the outset."

High Times started because there were many people who did not trust what the government published and they found no real place to go for information according to Mr Kowal. He said some 40 to 50 printers turned him down "but some people do believe in the first amendment and we finally found a printer."

Where to sell was just as difficult a problem and no national distributor would touch the magazine. Initial sales were mainly to marijuana dealers who bought hundreds and distributed it to clients.

Mr Kowal said some advertisers still shy away: record companies know the magazine reaches a large slice of their market but they're still afraid of possible damage to their corporate images.

Mr Kowal announced the magazine has been reorganized and is now owned by a charitable trust so profits go to worthy causes. NORML has been named benefactor of 50% of the profits.



'High Times' promotion shows its approach.

Pot to be tried in anorexia nervosa patients

By Harvey McConnell

WASHINGTON — Controlled trials using marijuana to induce an appetite in anorexia nervosa patients is planned in the near future by Norman Zinberg.

(Anorexia nervosa is a serious nervous condition in which the patient loses his appetite and systematically takes so little food he becomes severely emaciated.)

Dr Zinberg, chief of psychiatry at the Washingtonian Center for Addictions, Boston, said the trial will be carried out in collaboration with the National Institute of Health.

The decision is "based on evidence that our cancer chemotherapy patients report, without question, their appetites have improved. For the first time they feel they could eat and enjoy eating."

Dr Zinberg has been using marijuana as an anti-emetic in terminal cancer patients who receive high dose chemotherapy.

He said that in anorexia nervosa, the patients have lost their appetite so seriously that it threatens their lives. Dr Zinberg said he would use tetrahydrocannabinol (THC) in the trial.

Reviewing his work with marijuana, Dr Zinberg said: "I don't think marijuana is going to turn out to be a wonder drug. The medical usefulness won't come principally from the drug itself, and it is going to be used chiefly as an intoxicant."

Although marijuana and alcohol combined are unacceptable to many alcoholics, Dr Zinberg said there are some heavily alcoholic people who can be trained to use marijuana as a substitute.

When they are faced with a party, "or have a great impulse to change their consciousness and get out of the ordinary state which they find almost intolerable, if they can use marijuana quietly and gently in certain doses they find it quite effective."

Dr Zinberg said present restrictions stop him from giving smoke marijuana to women of child bearing age who have cancer, even though they are receiving nitrogen mustard at a level that makes pregnancy impossible.

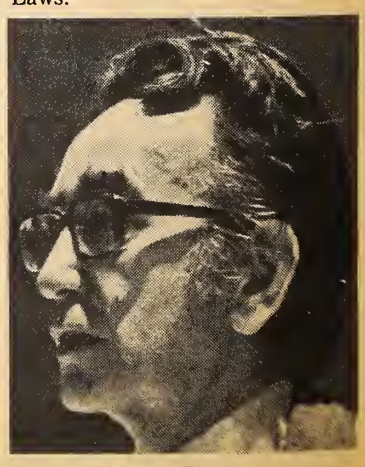
"In spite of the fact they are receiving almost toxic doses, it looks as though we will be able to give only one oral dose of THC."

He would like to use THC intravenously in children with leukemia, who suffer severely with nausea and vomiting, but administration is forbidden to anyone under 18 years of age.

Dr Zinberg said he hopes to demonstrate soon that tolerance to THC develops much more rapidly than tolerance to smoke marijuana. This is important because the anti-emetic effects occur only while the patient is exposed, to a certain extent, to a subjective high. If nausea breaks through before another high, then marijuana may not work again.

Dr Zinberg said that, overall, marijuana's usefulness is such "that it does not deserve the kind of hazards and various obstructions that have occurred."

Dr Zinberg was speaking here at the US National Organization for the Reform of Marijuana Laws.



Norman Zinberg

Addicts are losing out to pot users

WASHINGTON — A significant minority of American marijuana users are abused by being put into drug treatment programs, and this diverts hundreds of millions of dollars from care for hard drug patients.

David Smith, director of the Haight-Ashbury Free Medical Clinic in San Francisco, said discussion with drug program officials show the situation is general around the country.

"What I have found is very discouraging and shows we have a long way to go," Dr Smith told the conference here of the National Organization for the Reform of Marijuana laws.

He said over the past 10 years he has seen the odd patient who was inexperienced with marijuana and smoked a too high potency of the drug. But at hundreds of concerts his clinic has serviced, "I have almost never seen anything resembling even a pure acute reaction to marijuana."

However, a significant number of people arrested for possession of a small amount of marijuana are occupying the federal drug treatment system and this constitutes abuse in his eyes.

They are forced into this situation because the courts believe a jail sentence would be a mistake and the offenders should be diverted into drug treatment programs.

"The treatment programs get paid every time they treat somebody, and the easiest person to treat is somebody who does not need treatment," Dr Smith continued.

"These young impressionable people are referred to a heroin-oriented program, with counsellors and therapists experienced with heroin addicts, and there are a lot of junkies around. This is exposing them to a situation that is quite counterproductive.

"In addition, they still carry the criminal penalty related to the court system, so if they don't go to this junkie program, where they get abused, then they get put into jail."

This adds up to diversion of hundreds of millions of dollars from treatment for heroin addicts of whom there is a long waiting list.

Dr Smith cited the case of a clinic on Long Island, about which he was consulted, where approximately 38% of the people receiving National Institute on Drug Abuse funded treatment, were registered as either having no drug problem, or marijuana as their only drug problem.

The consequence was that a large number of people compulsively involved with heroin, barbiturates, and amphetamines could not get treatment becase the treatment slots were filled by people who did not really have drug abuse problems.

The Long Island drug program had to close, but NIDA has now revised the rules and there is a much stricter definition of what constitutes drug abuse treatment.

Dr Smith said there is still a need for the law to be changed to eliminate "this gigantic wastage of hundreds of millions of dollars that would have been much better suited for the treatment of heroin addicts, and money that all of us in treatment programs desperately need to deal with hard drug problems."

One positive benefit from lifting criminal sanctions in California is that an individual in possession of a small amount of marijuana does not receive the type of criminal penalty which allows him to go to the court system and then be diverted to a treatment program.

Doctor has dilemma with marijuana laws

WASHINGTON — Pediatrician Dorothy Whipple has fought to change American laws on marijuana but is loath to think of possible outcomes if it becomes reality.

"I have worked with youth throughout my career, and down at the bottom of my soul I hate to see kids start on marijuana at 11, 12 and 13," she told the conference here of the National Organization for the Reform of Marijuana laws.

If marijuana is legalized "one would hope ideally that they don't do it because of values they receive from their parents. I am not at all sure we can change values that one receives from parents by law."

Dr Whipple asked: "Are we going to give children free access to marijuana in cigarette machines? Maybe we will have to, but I kind of hate to think about it."

By Wayne Howell

Wayne Howell takes a more serious line than usual this month. His Comment appears on page 9.

Heroin is the minorities' symbol of oppression

WASHINGTON — Minority leaders in America are willing to become allies in the fight to change marijuana laws but only if the majority understand their situation in relation to heroin.

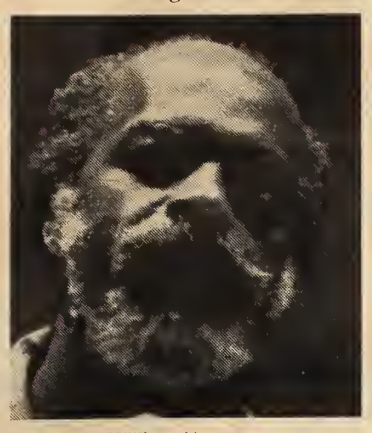
William Harvey, black director of the Narcotics Service Council, St Louis, says minorities have always suffered proportionately more in terms of differential application of the present laws.

In the 1950s and 1960s many were given stiff prison sentences for marijuana violations.

He told the conference here of the National Organization for the Reform of Marijuana Laws: "We need you as allies just as you need us, but we need you to help get across things that are important to us.

"Marijuana in our community is not seen by those concerned with such things as the great symbol drug of social oppressive practice and procedures. That distinction goes to heroin and methadone."

Dr Harvey said many of those attending the conference "are fond of drawing attention of the 'straight' white society to the fact that you are being prosecuted for choosing a drug, marijuana, that is different from their drug, alcohol.



William Harvey

"I think there is a similar analogy to be pointed out between your willingness to fight for freedom from prosecution for using marijuana, and not such a big willingness to fight for the freedom from prosecution for using heroin."

Heroin and methadone rank higher in concern of even the marginally informed black parent.

Most black parents differ from their white counterparts in not clouding issues with a denial of reality. They know what is going on.

Thus, when it comes to marijuana, Dr Harvey continued: "They believe their children more quickly than they do the police, physicians, and scientists, because they correctly see these individuals as maintainers and protectors of the status quo."

Blacks have always been arrested for marijuana: "It is not new, and next to heroin it pales into insignificance."

Dr Harvey said the black and brown communities are hit by three factors: "We are victims in greater proportion to our numbers; our young men and women are pushed into the so-called correction system and remain there; and insufficient attention is paid to prevention."

Rehabilitation is especially difficult in a minority community. Even without the problems of the courts, attempts to find jobs and a useful place in society, which often trigger drug use, are very difficult. The white community can draw on more resources which is why the rehabilitation rate is so low in minority communities.

Dr Harvey said there is a moral and philosophical question on the "right to get high — to escape present physical reality by a chemical at times."

The tragedy is that people who would not normally commit a crime, may do so under the influence of an addiction. The target victim can be anyone, even another poor person.

Dr Harvey said he sees an increasing use of heroin by the white community "and I think it is alarming."

He does not think it will approach the use by minorities. Whatever the increase there are better facilities for handling it than in the black and brown communities, he said.

Sleep of alcoholics, non-alcoholics differs

Alcoholism causes insomnia causes alcoholism

By Jean McCann

NEW YORK — Now it appears alcoholism causes a permanent kind of insomnia and, in turn, insomnia causes alcoholism.

A report here at a symposium on sleep and sleep disorders drew the connection between insomnia and alcohol.

"Symptoms of insomnia have been reported in follow-up studies of patients one to two years after successful withdrawal from alcohol. It has been theorized that alcoholism may permanently disturb the sleep mechanism."

On the other hand, the report noted: "In one study of alcoholics under treatment, interviews indicated that the amount of alcohol intake was dictated by the patient's felt need for adequate sleep, rather than by the anxiety or depression that may have been present. Perhaps many alcoholics originally started drinking to excess as a form of self-medication for a pre-existing insomnia."

Whatever is the case, it is certain the sleep of alcoholics differs from the sleep of non-alcoholics, according to the report. It was issued jointly by the Albert Einstein College of Medicine in New York, Montefiore Hospital and Medical Center in the Bronx and The Upjohn Company of Kalamazoo, Mich.

"The sleep of alcoholics is characterized by many night time awakenings and low total sleep time," it said. Also, the alcoholic has lower than normal amounts of deep and dreaming sleep, and a high frequency of shifts from one stage of sleep to another.

Speakers at the symposium stressed that abusers of other substances also suffered from disturbed sleep. These substances include opiates and amphetamines, as well as the hypnotic drugs which many individuals use to try to get some sleep, but which they soon become tolerant to, even at very high dosages.

Dr Milton Kramer, professor of psychiatry at the University of Cincinnati, for instance, said these substances may be involved in sleep disturbance because they are mood altering drugs. Such substances may cause interference with the mood regulating mechanism of sleep, although such a mechanism is not understood yet.

Explaining the relationship between stimulant and hypnotic drug dependencies, the report noted that "some patients who are given stimulants such as methylphenidate, phenmetrazine or amphetamines as therapy for other disorders, can develop tolerance to these drugs. In such cases, the patient cannot sleep without them.

"On the other hand, chronic taking of stimulants may lead to enhanced efficiency of the metabolism to break these drugs down. If that happens, effects of the stimulant drug may wear off during sleep, causing the patient to suffer night time awakenings, and complain of insomnia."

The report noted that when patients take hypnotics for sleep, the effect wears off in a few weeks, and then they often increase the dosage. But even after becoming habituated to large doses, the individual doesn't sleep well "although he must continue the use of the drug to get what little sleep he does."

The report suggested drug dependency insomnia be aided by a slow withdrawal from the drug — perhaps by omitting one dose every five to six days. The patient should also be counselled that he may have nightmares, but that these are due to changes in his body chemistry, and not to psychiatric problems. On occasion, a patient may also need a tricyclic anti-depressant, 24 hours after the last dose of stimulant, to help a resulting depression.

1000 youths a testament to drug plan

WASHINGTON — More than 1,000 young people have passed through a drug education program since Minnesota revised criminal sanction on marijuana nine months ago and not one of them has been arrested again.

Bruce Bomier, program director, said the state has realized a saving to local government of more than $500,000, and for the first time can gather comprehensive public health data regarding the flow of marijuana.

Above all, Mr Bomier told the conference here of America's National Organization for the Reform of Marijuana Laws, the program "simply hasn't hurt people."

"A low-key and honest drug education program has been functioning calmly, providing honest guidance in meeting the human problems surrounding intoxication."

Alcohol/drugs mask teens' sexual insecurity

WASHINGTON — "We are breeding a whole new generation of new age alcoholics," believes David Smith, director of the Haight-Ashbury Free Medical Clinic in San Francisco.

Young alcoholics in the making are only one manifestation of a burgeoning multiple drug abuse problem being reported more and more in North America and abroad.

Dr Smith said: "The multiple drug abuse problem really worries me. And we are seeing it essentially in non-psychopathological and non-compulsive drug abusing youth.

"We haven't even dealt with the compulsive drug abuse population. We are doing things, but we have our hands full just with that.

"Then all of a sudden on our flanks are all these kids being wiped out on alcohol and other drugs."

Dr Smith is in no doubt: "A number of these kids are going to end up alcoholics.

"We are barely dealing with the alcohol problem, and we are barely dealing with the heroin problem. Now we have this multiple drug abuse problem that there is no treatment system for."

The short term outlook is just as serious: youths are nearly dying of acute alcohol poisoning from combining alcohol with marijuana; and adolescent sexual patterns, always traumatic, are being complicated even more.

Dr Smith said he worried at first that his observations over the past two years would be regarded as another atypical "California problem," and dismissed.

"But I read that this is being reported in England (**The Journal**, December, 1976) and as I go around the United States to lecture I hear the same reports from others in the field," Dr Smith continued.

An interesting epidemiological factor is "many of these kids have had exposure to marijuana before they have had exposure to alcohol. It has been said that marijuana leads to heroin — well, right now, marijuana leads to alcohol."

Dr Smith said he saw the depth of ignorance about alcohol recently in a young woman patient who had the usual informed teenage knowledge of drugs and who had no drug problem.

"She told me she had smoked marijuana and drank at the same time. 'I feel terrible. I have a headache, a dry mouth and an upset stomach. I must have the flu'."

Dr Smith added: "I told her she had a hangover. Simply, she did not understand alcohol."

Ignorance of alcohol, especially in combination with marijuana, has almost proved fatal in several emergency cases handled by Dr Smith and his clinic team.

He explained: "These young people are unaware, just as the medical community is unaware, that marijuana has some sedative-hypnotic properties. Therefore, it is partially cross-tolerant when added to alcohol.

"A kid who is used to using X amount of alcohol and Y amount of marijuana, one day combines the two. He does not realize they are partially additive and it puts him over the top."

Complete intoxication, and often acute alcohol poisoning, is the result.

During the past year, Dr Smith's clinic has serviced more than 50 rock concerts, to which some 500,000 spectators flocked from over a wide geographic area.

Dr Smith said on one level the sample is biased, but on another, it is exposure on a mass scale.

There were no problems among the young people who chose to smoke marijuana during the concerts. "But we had between 20 and 40 kids a concert lying on our mats, passed out, and almost all had taken an alcohol-marijuana combination."

The doctors performed hospital medicine. "We had to clear the airways and monitor body signs, particularly diastolic pressure, to guard against them going into shock and dying of alcohol poisoning."

Fortunately, only one youth had to be admitted to hospital, "but under any other type of care system all of them would have been put in hospital," he pointed out.

Dr Smith said he has seen hospital records of patients admitted because of this drug combination, and in almost every case marijuana, and not alcohol, is given incorrectly as the cause.

"A little education on the spot" is enough for many youths. But there are repeaters, mainly "working class kids who are insecure about themselves, their place in society and, especially, they are sexually insecure."

These young men have the usual adolescent doubts about relationships with women and their ability to perform sexually, but they are more exaggerated. "So, they use alcohol, and if they get drunk they don't have to do it.

"Nobody says: 'You can't do it.' They just say: 'You are drunk, and can't do it.' If these boys don't perform, they don't get dumped on."

Alcohol, and the new mood of sexual liberation, puts just as great a pressure on girls. Parental pressure is to say "no" to sexual intercourse, and peer pressure is to say "yes."

Dr Smith added: "These girls are in a real dilemma. If they get drunk and disinhibited, and have sex, people can say: 'Oh, they just did it because they had been drinking.'

"So drugs are a way of giving a cover to some very complex adolescent psycho-sexual behavior."

The adolescent peer goal is intoxication. Unfortunately, most parents have been so worried about marijuana and other drugs, they dismiss the alcohol problem: "That's what I did at their age."

Dr Smith believes an educational thrust is vital. "We need to show them how to deal with adolescent problems without using alcohol and other drugs. Sex education is also very important."

What must be realized is these moves are necessary now. "This is not an isolated phenomena."

Youths are nearly dying from alcohol/marijuana combinations.

Gentle nomads' lifesblood . .

By Anne MacLennan

GENEVA — In the bureaucracies of Washington and Geneva and Ottawa, they have come to be pictured as fierce, rifle-bearing bandits doing an evil thing to the rest of the world.

But the thousands of people who live in the lush mountain regions where Thailand, Burma, and Laos come together are small, simple, and beautiful nomads whose tribal roots reach back into history and who through centuries have refined their own agricultural skills to a delicate perfection.

As Canada's Algonquin Indians once followed the cariboo to feed and clothe themselves, so still do the people of what has become known as the Golden Triangle, seek out and find with exquisite precision, the land which will provide them, for a time, with their economic lifesblood and their only medicine — opium.

When they've slashed the jungles, burned off the land, and planted and harvested their opium poppies — sometimes they have five good years before the land dies on them, sometimes more — they move on to another slope on another mountain and yet another five to 10 years of existence.

They know that each year, along about February, strangers from the lowlands with mule caravans will come and trade some silver money for the gummy brown liquid they've collected from the poppy pods. With the silver, they'll buy the rice that is their food. That is their reality and it is primitive.

They do not know New York exists. Or London or Vancouver or Amsterdam or Chicago. And they've never heard of dope pushers, methadone maintenance, cold turkey, the Mafia, dealing, or horse.

Yet, it is estimated, and there can only be estimates, that from these essentially gentle, primitive people and their crops, come up to 700 tons of opium each year, or perhaps 50% of the world's supply of illicit heroin. This is another reality. Neither gentle nor primitive.

The couriers, waiting in Bangkok, about 400 miles and a civilization away through the jungles from the hill villages, are a part of this other reality.

Liselotte Waldheim-Naturel is a program officer in the operations section of the United Nations division of narcotic drugs. The Golden Triangle is her area and many of the villagers her friends. She visits them regularly.

"The couriers are not brave . . . they are reckless and desperate for money. Usually, they are unconcerned people who don't know much, if anything, about the structure of the vast and rich organization of which they are a part. They are simply hired. For a certain amount of money, poor people will do just about anything."

They are also clever, she says. Or at least the people who organize them are.

"There may be four or five couriers travelling on the same airplane on the assumption that if one is caught, the other three or four will get through."

The assumption is incorrect only in that it underestimates. According to Madame Waldheim-Naturel, INTERPOL believes it catches only between 5% and 10% of drug couriers.

Strangers must gain trust of villagers. . .

Photos: H. David Archibald

The heroin that has been processed from the mountain opium in laboratories strung along the route between the hills and Bangkok, may be ready in days. Not as bulky as opium and without its strong odor, it may be hidden and transported easily.

For more money than the hill farmers receive for a year's crop, the couriers leave Thailand by sea and air to deliver their cargo, often in a matter of hours, to connections around the world.

Another part of this reality: about 85% of the heroin that is injected into the arms of another gentle, if more advantaged people, Canadians, comes from the Golden Triangle. This is according to the Royal Canadian Mounted Police.

This source, demand, and trade link between people on different sides of the world, is vicious and complex. And it will be simplified or ignored by Canadians and Americans at their ultimate and serious expense, says H. David Archibald.

Mr. Archibald, founder and former executive director of the Addiction Research Foundation of Ontario, is now executive vice chairman of the ARF. For many years, he has acted as an advisor to the World Health Organization and the United Nations in Geneva.

On sabbatical last year from the ARF, he was on special assignment with the WHO, commuting between Geneva and the Golden Triangle, flying over uncharted mountain country into the hill villages of the north by Royal Thai Police helicopter, a tool of the law enforcers.

Mr Archibald's mission, however, was and still is to try to illuminate the scattered threads that tie together — more than any of them realize — the fate of the primitive village tribesman, the Toronto addict, and even the Geneva shopper.

That there must be concern in Canada and the United States about the Golden Triangle is, at one level, obvious, he says.

Although the vast majority of illicit heroin now entering the US is from Mexico, some, filtering through Canada, is from the Golden Triangle.

"And certainly, the Golden Triangle is the source of most of the heroin that is touching the lives of Canadians.

"By straight definition, we have to be concerned on that level."

However, there is another higher level. It has to do with preserving western society.

"We ought to be concerned on a much more generalized but more humane scale. It seems to me we in the developed world, and Canada specifically, have a responsibility and a moral obligation to be concerned about being of maximum assistance to people in the so-called third world and especially to the people in rural populations.

"In economic terms, we get blessed little out of it. But, if we value our way of life in this western world, and I think we do, then we should be concerned about the fundamental factors that are leading to major revolutions and major changes in the system and the way of life of the eastern network, of the so-called developing countries. This inevitably has a very major spillover, into western society.

"In the long run, what's in it for us I think frankly, is self-preservation."

The questions of who to help, and how, are legion. So are some of the solutions.

Thailand in ways, however, has become a pilot project. What is being learned there may help not only other developing countries, there may also be some lessons for the west.

The lessons are not yet ready for tough handling or transplanting to the west. Rather they are tendrils of ideas. They may have been waiting in the third world for the west to see them or they may be growing now because there is room for them to grow.

In either case, the process has taken time.

The conditions of the west that tend to allow people to live long lives, don't exist in the mountains. Of those few who do grow old, many are addicted to smoking opium. Measurement of addiction and its effects are crude but if a man smokes 10 pipes a day, he's addicted. If he's addicted he may no longer be relied upon to help in the opium fields.

But, most people in the mountains die young. So few if any of the villagers now preparing to harvest their February crops, were alive when international concern about illicit heroin production and trafficking began to be formalized.

"The narcotics division is as old as the United Nations and older because it operated under the League of Nations," says Waclaw Micuta, recently retired director of operations for the UN division of narcotic drugs.

"The oldest international treaties started from 1912."

One would prefer now to look back and see that, from the beginning, action was broad, humane. But then, as now, there were the rich and there were the poor and the concern gradually and apparently naturally settled on how the rich could protect themselves.

David Archibald: "The major approach historically within the United Nations system and in the United States and Canada and indeed throughout the world has been, I think, essentially a law enforcement approach on the rationale that if you can eliminate, first of all, the source of supply, and certainly eliminate the international traffic, then by definition you'd eliminate the problem or prevent the problem from occurring in the first place in the streets of Chicago or Toronto or Vancouver."

The focus on law enforcement finally crystallized in the late 1960s and early 1970s with the dramatically increasing numbers of heroin addicts and related crimes, especially in the United States. And in 1971, the United Nations Fund for Drug Abuse Control was set up.

Because there wouldn't be enough money in the regular UN budget, the fund would draw on voluntary contributions from governments, non-government organizations, and private sources, to provide the financial muscle necessary to implement control and development programs.

. the heroin addict's requiem

The message from donor countries through the fund to the division of narcotic drugs was: do something. The most generous country was and is the United States and its voice the loudest. Enforce the law. Get rid of the illegal supply and we'll get rid of our problem.

Enthusiasm for law enforcement was fervent. David Archibald recalls: "They used to stand up and clap at UN meetings when someone announced they'd introduced the death penalty for traffickers."

Although the mountain villagers tending their crops didn't know it, the Golden Triangle and particularly Thailand were to be in the first line of fire. There could only be educated guesses but the Golden Triangle was believed to be the most prolific source of heroin, with the northern tribesmen of Thailand producing opium and Thailand itself acting as a transit route for production from mountain villages in Burma and Laos.

Madame Waldheim-Naturel: "The pressure of world public opinion on the Thais was enormous at this time. People were saying: 'Look here, you can't just close your eyes to the problem you've got in the north.'

"The Thais were fully aware they were suffering from all aspects of the drug problem. They were and are an illegal producer country, an illegal consumer country and, in addition, an export and transit country for illegal drugs from the north.

"So, in 1971, the Thais said: 'All right. The world has pointed its finger at us. You've studied the problem, you give advice, but we haven't the financial means. Now, you've got the funds.

"This is why we started there. And it became, in a way, our demonstration project."

Although law enforcement was then and still is the financially strongest arm of the fund, by itself it was, at best, impracticable. At worst, it was inhumane.

Says Madame Waldheim-Naturel: "It simply can't be done by enforcement measures alone. It's very easy to say destroy the fields. But the police would have to destroy the source of livelihood of many thousands of people. It's not a very rewarding policy. It's very difficult to accept as a human being that just because it's harmful to the rest of the world, we should deprive these people of their source of livelihood without giving them something else."

The "something else" proved first to be crop substitution although the term had not yet been formulated.

David Archibald: "Recognizing that the economy of the villages is very largely based on the production of opium, that one was looking at a family or village structure in which opium was the major cash crop, and many other factors, the UN began to think of terms of testing out the possibility of teaching the essentially rural agricultural folk to grow crops other than opium and find out if it would be possible for villages to maintain themselves economically through other agricultural crops. Hence, a major program of what is now known as crop substitution was devised and developed."

If the concept is familiar now, it wasn't in 1971.

Mr Micuta explains: "We started on a trial and error basis internationally. When we went first to Thailand to the mountains, nobody knew what the climate was, nobody knew what the rainfall was, nobody knew what the temperature was, the degree of humidity, the soil, the water. Nothing.

"It was terra nova and it was terrifying in its immensity. Slowly, slowly, we learned and we were lucky."

Nobody had ever thought before of going to the producers of illicit opium to find out how and why they produced it. "I think this was a contribution on our side. For the first time ever, we discovered exactly what it means to produce opium.

"We found out first of all, that the people are much more clever than anyone thinks. If they can master production of opium, they master any other production.

"We discovered it's a very labor intensive production. You must clean the field, put in the seeds, fight against weeds. Finally, when you are lucky, you have plants and capsules. Then, there is one week when there are capsules — green capsules without flowers. This is when you catch the opium. If you miss it one week, there is no production.

"Why do they produce it? Because first of all, they can sell opium and fetch some kind of price, and it's never as good a price as people think it is. But, they can get a price which they consider fair. And marketing is assured.

"This, and a great many other secrets we learned. And nobody ever knew it before. Certainly, we didn't and this is a very old division and had accumulated a lot of knowledge. So, we came to the conclusion that if we started offering these people other crops with similar advantages, they would probably go ahead with them. And this proved to be true. Which is why we have reason to be satisfied because we started with a complete zero."

If there were new discoveries, new problems also emerged.

Says Liselotte Waldheim-Naturel: "It's not like the opium caravans which go in and pick up the stuff at the villages. The villager has to market his new crop, take it down to the market. If you want him to look halfway decent in the context of the plains, he'll have to start being a little bit more hygienic than he was, because he used to have to walk for about a half hour or three quarters of an hour to the next waterwell.

"Obviously, he would bring water for drinking and cooking but not for washing. So, you have to introduce water. . bring him at least into the framework, the distant framework, of our concepts of cleanliness. Otherwise, he'll be despised by the Thais or the city dwellers who are generally very clean people.

"Then you have to think it's the only pain killer. If you prohibit him from growing opium, if he has a toothache, or a stomach ache, or is dying, the only way not to suffer too much is to take opium. If you're prohibiting him from growing opium, you must give him some better, at least basic, rural health care, modern medicine he can replace it with.

"So you have to set up a health station and bring in central village waterwells. Then, if the people are supposed to deal on a commercial basis with legal crops, with the lowlanders, which is what one tries to do is make an integrated, smooth transit to the normal economy, they have to know how to calculate. They have to know how to speak the Thai language.

"This means you have to build them a school, you have to train a teacher who will know the tribal language."

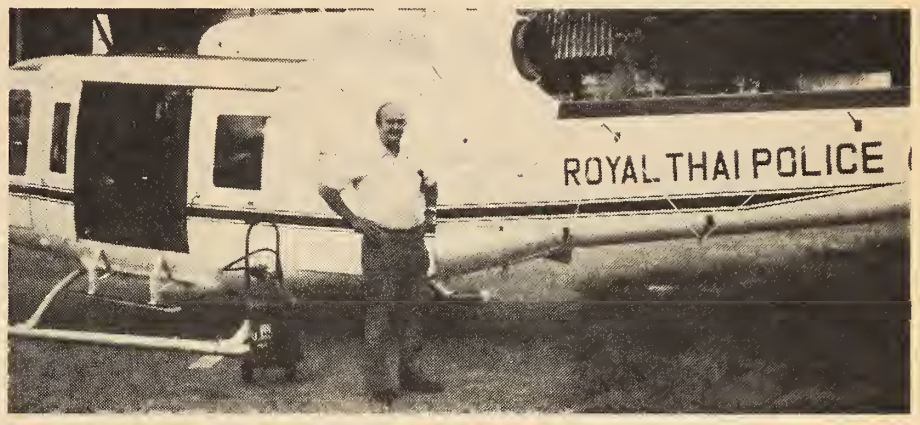
The cost? On the one hand, it's ridiculously small. What would run into thousands and thousands of dollars in the west, costs relatively very little in, say, Thailand.

For $50, a village health station can be built. For $1,000, a clean water supply can be installed in a village. A health officer, a "barefoot doctor", will work in a village for $900 a year.

On the other hand, the UN demonstration project is operating in only five key villages and 25 or 30 satellite communities. And there are an estimated 5,000 villages in the Golden Triangle area.

"We do it literally with good will, with idealism. We thrive, I think, on idealism. And sometimes I think people don't understand it," says Madame Waldheim-Naturel.

One of the crop substitution projects involves white kidney beans and that's where the Geneva shopper ties in.



H. David Archibald

"The bean," says Mr Micuta, "is a very resistant plant, grows rather easily, and is a very high protein food."

It isn't surprising, however, that many of the villagers did not at first take kindly to substituting beans for opium.

"Whether this is in Paris or in the Golden Triangle, if you come to people with new food, the answer is no. Ask the French to accept Hungarian food, they will say no. Of course the villagers said no, it would give them stomach cramps."

So, rather than grow them and eat them, the villagers were given the chance to grow the beans and sell them and, for the first time in history, the United Nations was in the bean buying business.

"In Geneva now, you can buy kidney beans produced in the Golden Triangle and we can buy as much as they produce. And this simple crop, which was not thought of as a crop substitute, took a great number of marginal opium fields out of production."

David Archibald says the program is a "long way from making a major impact on opium production in itself because they're working only in five key villages and perhaps 25 satellite villages. However, it's a pilot demonstration and the degree to which this type of program will be picked up and applied more effectively and more extensively throughout the hills depends, in the final analysis, on the commitment of the Royal Thai Government.

"The evidence thus far," says Mr Archibald, "seems to indicate the government is committed and may even be increasing its commitment."

Although crop substitution began as a specific entity and tends to be discussed as a specific entity, alone it cannot provide an answer.

"One fundamental feature that has now become an important concept in the whole approach to drug production and programs in essentially rural agricultural communities in the east, is the fact that opium is the only medicine these people have, says Mr Archibald.

"In one sense, opium is a very marvellous medicine for what we'd call symptomatic relief of the symptoms or the diseases common through the area — dysentry, coughing as a consequence of tuberculosis, gastro-intestinal infections, and other ailments common to older folk.

"But, it's the only medicine available. When you realize that, it becomes a much more complex and fundamental problem than simply eliminating the growth and production of opium in the villages."

In terms of illicit opium production, Mr Micuta has the last word: "Illicit opium will always be with us and I think we should be a bit wise about that.

"If you are in the high mountains and it is cold and rainy and you're old and you have a toothache or rheumatism and you've been smoking for many years, who are we to argue you shouldn't have a smoke in the evening? Who are we to argue that someone here shouldn't have a whisky and soda?

"We are not here to liquidate all whisky or all opium. We are here to protect the international community from abuse. And I think with opium, we stand a better chance than with whisky."

That leaves health care. And Mr Archibald has this to say: "From my point of view, and now I think from the World Health Organization point of view, one has to concentrate in these areas on the development of basic health care services as the major mechanism to improve the health facilities in the village areas and certainly begin to provide methods of preventing, in public health terms, the disease and health conditions that there are there.

"In terms of the systems being developed, I would submit that the west has much to learn."

* * *

Next month, **The Journal** *looks at the World Health Organization's new policy on health care delivery in developing countries and what lessons the west may learn.*

Liselotte Waldheim-Naturel and Waclaw Micuta (far right) check a mountain crop with the aid of a Thai official.

Canadians want a study of licit opiates trade

(from page 1)
actions were taken negating these careful negotiations over the past 20 years, which resulted either in cessations or in restrictions of cultivation solely to domestic needs.

"Unless all possible consequences are put before the world's decision makers in this field, decisions may be taken which will result in worldwide over-production in the international market, and a consequent fall in prices, resulting in financial stringencies which will impose a severe burden on the main producing countries in their measures to prevent any leakage into the illicit market."

Calling for an economically-based study of the international trade of licit opiates, the working paper says: "Canada, as many other countries in the world, has voluntarily abstained from growing any narcotic crops. We do not have the same access to the technical and economic facts upon which decisions are made as do producing countries, yet we, as consumers, along with most of the other countries of the world, are and will be the victims of high prices and unstable markets.

"We also have a suspicion that producing countries are likewise operating 'in the dark' when it comes to knowing the intentions of other producing countries and estimating effects on world markets.

"What is wanted here is an international assessment of the facts, taking into account technological, economic, and social consequences of various courses of action. Obviously, the INCB (International Narcotics Control Board) is the body to be in charge..."

The crux of the problem is the delicate balance between supply and demand for licit opiates — codeine accounts for approximately 85% of world opiate consumption — and the effects of shifts in that balance.

The fear is that the US, acting possibly out of nervousness about a codeine shortage and high prices but acting independently nevertheless, will dangerously shift the balance: an increase in worldwide production of opiates could lead to a worldwide fall in prices, creating economic hardships in some countries legally producing opiates for world markets under the authority of the United Nations.

Economic hardships could, in turn, lead to weakened control and enforcement measures and leakage of legally produced opium to the illicit market.

Turkey, for instance, has shifted from illicit to licit production of opium poppy under extreme pressure from the United States and has had no reason to believe the US and the international community were not acting in good faith when they supported the move. Turkey is now building a large extraction plant reported to be of 20,000 tons capacity per annum. In 1975, Turkey processed only 6,000 tons of poppy straw.

With the shift to licit production and with the future assured for its opium growing peasant farmers, Turkey also strengthened its control measures to prevent leakage of opium to the illicit market.

If less money is flowing into Turkey for licit products, there may be less money available for control and Turkish farmers may turn, once again, to the illicit market.

If the US move stems from fear of a codeine shortage, it may be the trip through the bureaucracy has made it about two years out of date. It now appears US scarlet poppy production for about 25% of its own codeine needs would not only be harmful to other countries, it would also be unnecessary.

Canadian officials have studied present production and production plans of the five countries currently in licit opiates production for the world market — India which processes opium and poppy straw, and Turkey, Australia, Iran, and France, which process poppy straw. With experience and improved technology, all of them are planning increased production, in some cases quite significant increases.

Again, Don Smith and Canada's working paper: "The conservative extrapolation which would lead to the conclusion that demand and supply would be in balance by the mid 1980s depends upon no further production increases beyond those already announced.

"Assuming that those courses of action which are already in train or have been announced will have the indicated results... it is apparent that there is probably already over-production on a world scale beyond what is needed for current maximum demand..."

Graphs in the Canadian working paper show that by 1980, the accumulated excess production may amount to as much as 300 tons of morphine equivalent.

More than a year ago, in its report of the fourth special session in February, 1976, the UN Commission on Narcotic Drugs also warned of the possible problem of overproduction of opiates and said it "would constitute a step backwards for the system of drug control.

"A number of representatives insisted on the fact that, since the period of crisis appeared to be over, more thought should be given to reaching an equilibrium for the future.

"Extreme caution was needed when the problem of balancing supply and demand in respect of opiates was dealt with, since so many elements were involved," says the report.

Whether and when the US will go ahead with planting is still a moot point. For one thing, as one American official put it: "We can't plant when the ground is frozen."

A more serious question is whether the international treaties can prevent it. Some say the scarlet poppy does, or at least should, come under the strict control of the Single Convention on Narcotic Drugs or its amendments.

However, every country has a treaty right to produce for its own consumption and some say the scarlet poppy is free of treaty strictures.

Sheldon Vance is senior advisor to the Secretary of State on International narcotics matters and executive director of the president's cabinet committee on international narcotics,

He told **The Journal** that America could go ahead any time with commercial production of the scarlet poppy and about the most the International Narcotics Control Board could do would be to disapprove.

Ambassador Vance, however, is against the move.

"When we urge countries that have production that leaks — Afghanistan, Pakistan, Thailand, Burma, and Mexico — we are in a much stronger position, together with the UN and governments like Canada, to ask them to refrain or to make greater efforts, if we are not a producer.

"We have abstained, as has Canada, from using our treaty right to produce for ourselves. That abstention has been in order to support this policy.

"If we go into business and grow the scarlet poppy even though it is a different poppy, it will be a little difficult to explain, we think, to some of the governments that it is a different poppy.

"They will be unable to see why they should spend, as developing countries, scarce resources, and even risk the lives of their soldiers and policemen, when we merrily, in response to urgings here, are in the business. They will think we are protecting our new competitive position."

Ambassador Vance also said he was not impressed by the argument that America should produce some of its own codeine to protect itself from high international market prices.

"We think the price argument is not a very strong one and certainly not one that will counteract the risk of much greater illegal supplies being available for import to the US."

As for a possible shortage, he said America lists opiates among the myriad items that have to be kept in a strategic stockpile. "This includes what amounts to a year's supply of our requirements for codeine and the like. In addition, our pharmaceutical companies are estimated to have at least six months consumption in stock.

"If by some strange series of events we were cut off, we could grow the opium poppy in three months. The department of agriculture has been prepared pursuant to our strategic stockpile legislation to grow it on government land. Thus, during one summer, with the seeds that we have in stock, we could grow all the opium poppy we needed.

"There is absolutely no sense to it at all. If you do not know the facts, you sort of think along the lines of petroleum. It is not at all like that. We have abstained from using our admitted legal right to grow it but there is no reason I can see that is worthy of consideration in view of the grave risks that would be entailed."

Exactly when the final decision will be made is unclear. Public hearings in Washington have been scheduled and the matter will be discussed at the Geneva meeting in February.

Broadcasters fight ad ban

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coast broadcasting of events like hockey.

And, this wouldn't ensure that sensitive younger viewers would necessarily miss the alcohol ads.

Mr Lalonde has talked about a nationwide ban before 8 pm and 9 pm, as at least one province has implemented.

The CAB urges advertising to promote moderate drinking rather than the required health warnings that Mr Lalonde is promoting.

The private broadcaster members of the CAB make about $16 million dollars a year from beer and wine advertising. Hard liquor advertising is banned, but the CAB is pushing for a lifting of the restriction.

The association warns that if advertising restrictions are too severe, all advertisers could be forced to go elsewhere, thereby undercutting financial support for Canadian programing.

They also note that despite beer and wine advertising, and the ban on hard liquor advertising, consumption of hard liquor in recent years has actually been growing more rapidly than the consumption of beer and wine. And increases in beer consumption have been no less in provinces where broadcast ads are restricted.

The association notes that broadcasters have been involved in a fight against alcohol abuse through public relations programs and public service announcements. The broadcasters are also carrying government advertisements promoting responsible consumption of alcohol.

It is also noted in the submission that restrictions on Canadian radio and television alcohol advertising would still leave comparable advertising on US television stations, which many Canadians watch on cable television systems.

Strategy Council on Drug Abuse

US pot use is near saturation point

By Harvey McConnell

WASHINGTON — Drug abuse remains at unacceptably high levels throughout the United States, according to the annual report of the government's Strategy Council on Drug Abuse.

It estimates that over the past year, some 22 million people have used marijuana, seven million have used prescribed medication without medical supervision, three million to four million have used cocaine, and more than 500,000 have used heroin.

These figures do not represent a radical upward trend, but drug abuse continues to be "a persistent and chronic problem."

Alcohol remains the most widely used and abused drug. The report finds, however, "very little has been done to integrate the community-based activities dealing with the problem of alcohol abuse and the abuse of other drugs."

Heroin use has stabilized since the last quarter of 1975, although availability has decreased slightly over the past year. This could be caused by the campaign against opium poppy growing in Mexico.

Chronic use of barbiturates continues to rank with use of heroin and tranquillizers as a major social problem. Availability of cocaine has increased over the past two years, but there does not appear to be an increase in use.

Marijuana use is approaching a "saturation level."

The report said that in light of the widespread recreational use of marijuana "society pays a relatively high price" under the present system of criminal sanctions.

It is a high price "in terms of diverting limited criminal justice resources from other, more serious matters, and high in terms of contributing to an atmosphere which nurtures disrespect for the law."

The report said the government "should take the lead in mobilizing the enormous potential resources available in state, local, and private prevention, treatment, and rehabilitation services.

"Only through full utilization of all available resources and close cooperation among all its involved agencies can we hope to reduce the extent of drug abuse in America.

"More importantly, we must enlist the aid of communities and families in the fight against drug abuse."

The report said cooperation with foreign governments to combat drug production and smuggling has improved, but narcotics intelligence gathering remains weak and improvements are needed critically.

In the research field, the report said priorities include:

- An increase in the understanding of the social and individual causes and consequences of drug abuse;
- An increase in the knowledge about the long term effects of drugs, such as cocaine.
- Assessment of the exact relationship between drug use and crime;
- An improvement in treatment through development of longer acting opiate maintenance and of narcotic antagonists;
- Continued basic research on the pharmacology of drug use.

Roadside tests get okay in Sask.

OTTAWA — Saskatchewan becomes the sixth province in Canada to join the federal government's roadside breath testing scheme, under recent amendments of the Criminal Code.

Effective in January, police in the province may stop drivers suspected of drinking and subject them to a screening test to determine whether they should have a more precise alcohol breath test at the local police station.

The screening test will not be used as a basis for convicting a driver of impaired driving. But, people who refuse to take the screening test, will be subject to the same penalties as those who are found guilty.

To date, one breath screening device has been approved for use in Alberta, Saskatchewan, the Northwest Territories, Yukon, Ontario, New Brunswick, Nova Scotia, and Newfoundland.

It is the ALERT or Alcohol Leval Evaluation Roadside Test model J2A-1,000, manufactured by the Borg-Warner Corporation.

Twenty-year British study shows smoking's devastating

By Alan Massam

LONDON — The British anti-smoking lobby has received a major boost from a report in the *British Medical Journal* which shows the medical implications of the habit are, in a word, devastating.

The report was the final summing up of a 20-year study of the smoking habits and health records of more than 34,000 British male doctors.

In the period from 1951 to 1971, 10,072 of the doctors died. The certified causes of deaths and changes in smoking habits were recorded.

Authors of the report, Professor Sir Richard Doll of the University of Oxford and Richard Peto of the Imperial Cancer Research Fund, conclude that among men under age 70, the death rate ratio of cigarette smokers to lifelong non smokers was about 2:1, while for men over 70 it was about 1.5:1. (Sir Richard, with Dr M. P. Vessey, published in the early 1960s the first report linking cigarette smoking and lung cancer.)

This means, they say, that if the excess death rates are actually caused by smoking, then about one third to one half of all cigarette smokers will die because of the habit.

The careful records of the survey show that as the proportion of smokers in the doctor sample declined, lung cancer grew relatively less common among them while other cancers did not. This is considered to have illustrated in an unusual way the causal nature of the association between smoking and lung cancer.

Following publication of this evidence, the Royal College of Physicians' sponsored ginger group, Action on Smoking and Health, said it must prompt the government to establish a long term program to deal with the smoking problem.

Officials of ASH said they would meeting the secretary of state for social services, David Ennals, to press for a strategy aimed at preventing children from starting smoking.

They said they wanted to see increased expenditure on anti-smoking campaigns, a ban on tobacco promotion, regular tax increases on cigarettes, and more education for children on the ill effects of smoking.

The director of ASH, Mike Daube, said: "Britain now lags behind other countries in terms of smoking control. The government must now stop pussy-footing and produce a long-term plan to reduce smoking and the associated death toll."

A leading article in the issue of the *British Medical Journal* (December 25, 1976) carrying the Doll Peto report said the investigation "sets out in detail the toll that smoking takes from human life, in both mortality and lingering ill health."

It showed that the chief ways in which smoking caused death, especially in middle-aged men, was by heart disease, lung cancer, chronic obstructive lung disease, and various vascular diseases.

Furthermore, smoking was a contributory factor in other conditions, sometimes fatal, such as peptic ulcer, cancer of the bladder, and hernia (provoked by coughing).

Between 1951 and 1971, the average number of cigarettes smoked per day by doctors fell from 9.1 to 3.6 and this had contributed to the steady decrease in the incidence of lung cancer deaths in those aged under 65.

The BMJ concludes: "This latest report by Doll and Peto consolidates and amplifies the mass of evidence that smoking is a most serious health hazard and one which is preventable. Doctors as a group have improved their health expectation partly by younger ones not starting to smoke, but mostly by older ones giving up smoking or reducing the number of cigarettes smoked.

"Why is it so difficult to induce the rest of the population to do the same? . . . A fresh offensive is needed. A summary of Doll and Peto's report should be made available to every doctor, schoolteacher, and others concerned with advising young people."

The campaign fully to inform the public about the perils of smoking will be given greater impetus by the appointment of Sir George Godber as chairman of the government-sponsored Health Education Council. The monocle-wearing Sir George is former chief medical officer to the department of health and social security and a dedicated anti-smoker. He is also a formidable personality.

Diplomatic agreement gets top priority

Enforcement alone can't stop heroin

(from page 1)

most significantly affect the availability of drugs. Probably way ahead of anything else is diplomatic agreement.

"If it is the right one, and it is carried through, one can eliminate the total supply of a drug."

For the moment, the US is waiting to see what success the Mexican government will have against illegal opium growing. "If it turns out as well as it might, it could result in a 50% to 60%, or even higher, cut in the availability of heroin."

No amount of law enforcement can produce this result. Dr Bourne said: "I think the DEA (Drug Enforcement Administration) and customs people themselves would be very ready to admit that 10% of the total flow of heroin is the most they hope to be able to stop.

'There are a lot of countries with a vested interest in reducing the drug problem. . .'

"Obviously, then, you have to give diplomatic agreement top priority."

American efforts will differ between a country like Mexico, where major opium growing started recently, and countries where poppy cultivation has gone on for centuries.

He explained: "In Mexico there was not that significant indigenous cultivation of opium to begin with, and the people were not dependent on it. This is a bonanza they have suddenly caught on to in the last couple of years."

Herbicides with no residual effects are being sprayed from helicopters obtained from the US. Unfortunately, the effect is only on the growing crop and seeds may be replanted immediately.

Despite rumors to the contrary, Dr Bourne said to his knowledge no helicopters had been shot down and only one has crash landed in the mountainous terrain.

The Mexican effort, if successful, will put the farmers back to where they were two years ago.

"Now they may be poor and entitled to improved standards of living, but I don't think one is really victimizing them, particularly by stopping them from cultivating opium," Dr Bourne continued.

The Mexican government has "begun to see the potential damage to their people of having heroin trafficked and cultivated. They want to take measures to stop it before it really gets out of hand.

"So I don't think we are really penalizing the Mexican peasant that much."

The problem is much more complicated in countries such as Afghanistan and Pakistan where people have grown opium for centuries and it is part of the lifestyle.

There, crop substitution programs are important.

But, Dr Bourne continued, "whether we should pay for them I don't know.

"There are a lot of countries which have a vested interest in reducing the drug problem. One of the concerns we have is that the rest of the world kind of looks to the United States to finance the anti-drug efforts and I don't think that is appropriate.

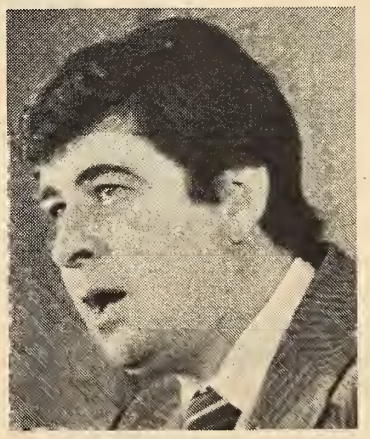
"Iran has the highest per capita incidence of narcotics addiction in the world and they have a pretty good economic base. A lot of the European countries now have a serious narcotic problem.

"So, I think other countries have to be more willing to contribute, particularly to the UN fund and the international effort to get to the sources of opium, and to support such things as crop substitution programs."

Dr Bourne said a more important issue is social development in the opium growing countries.

"Whether they were growing opium or not, and whether it was coming and creating a problem in the United States, these countries are developing very rapidly into the 20th century.

"To be reliant on a single crop that has a limited market probably is not appropriate for these countries anyway, and they should be thinking about changing, just to broaden their economic base."



Peter Bourne

Another major problem is that in many countries opium growing is in areas not under complete political control of the central government. In order to gain this control, roads, among other things, need to be put into the areas.

Dr Bourne predicted: "That's going to happen. I think you are going to see in areas of Pakistan, of Afghanistan, and even of northern Mexico, a gradual move towards greater control by the central government.

"As part of that, whether it is opium or not, you are going to see the central government wanting to encourage people to diversify their crops, to diversify all of their local economy."

'. . . These countries are developing very rapidly into the 20th century.'

Thus, there are many factors not tied to opium itself and it is important for the United States to play a role in this social development.

Dr Bourne said the president "is very concerned about social development around the world and, I think, particularly in the developing nations, has a much greater sensitivity than the last two presidents had for this kind of issue."

While diplomatic effort will receive top priority, treatment is another very important consideration, he said.

"I think it can reduce consumption of heroin if you have adequate treatment. So I would put treatment up there close to, if not ahead of, law enforcement.

"But I don't think law enforcement should be reduced. I think it is a question of doing it in a way that is inoffensive and that's most productive.

"I think concentration should be primarily on the really major traffickers, and with rather a minimal effort on traffickers of small amounts."

"If you reduce the penalties substantially you do, to some extent, undercut the illicit traffickers. At the same time, you maintain enough discouragement to stop people from using heroin excessively."

Canny Kentuckians would like to try marijuana business

WASHINGTON — Many canny, and poor, Kentucky hill farmers would be in favor of growing legal marijuana along with tobacco.

This is the claim of Gatewood Galbraith, president of the Kentucky Marijuana Feasibility Study, Inc., a non-profit body.

Mr Galbraith was here to lobby support from delegates to the conference of America's National Organization for the Reform of Marijuana Laws. He estimates legal marijuana would increase the average hill farmer's income by $3,000 to $5,000 a year. At the same time, the state would garner badly needed revenue for health and education programs.

A final year law student at the University of Kentucky, Mr Galbraith, whose long, lean, and courtly appearance would make him a sure candidate for the role of Ashley Wilkes in a remake of Gone With The Wind, said his group will put a member up for state office in the next election in order to educate the public and explain the group's position.

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Letters to the Editor

Frustrating drug policy

This letter was prompted by a recent visit to a number of agencies and organizations in Washington, DC. My experiences there brought into focus an issue of which I have been vaguely aware for some time: that is, the relative merit of spending money and effort on drug rehabilitation and control as opposed to education and information dissemination.

In discussing funding possibilities for information projects, I discovered that many people have very different funding priorities and philosophies than our own. Our position is that information and education, although they require long term investment, are ultimately some of the most rational and least expensive methods of dealing with the "drug problem."

The response to this concept was, almost universally but at times apologetically, that the idea is fine on an intuitive level, but since such programs are virtually impossible to evaluate in terms of demonstrable statistical results, agencies are generally reluctant to fund these types of projects on a large scale.

Patricia Cleckner

What is so interesting about this position is that the programs which have received the bulk of funding in the United States and for which sophistocated evaluation techniques have been developed, have *not* demonstrated reasonable success rates, nor have they made impressive inroads on the problem. Regulation fails to end illicit traffic and diversion of licit drugs. In the eyes of some observers it exacerbates the problem by making it necessary for users to engage in other forms of deviant behavior in order to obtain drugs.

Rehabilitation by most statistical evaluations is blatantly ineffective. One small example of this is the fact that, of all clients reported admitted to treatment in the United States between January 1, 1975 and March 31, 1975, 19.6% were employed full time on admission and only 20.3% were employed on discharge. (CODAP Statistics — September 1975) Yet both types of programs continue to be funded without major innovation.

This seems to me to be just one more example of the sociocultural and political absurdity of prevailing drug policy so frustrating to those among us who seek genuinely rational and effective methods of dealing with the "problem".

Patricia J. Cleckner, PhD
Director of Research
Up Front, Inc.
Coconut Grove, Florida

Cold memory

It is a treat to read your story on the battle we have won here to keep real beer in Britain (**The Journal** January). I am delighted to see the point made that we, the little people, can win against the giants.

Now, what about you Canadians doing the same thing? As a student in Canada I had to force myself to drink glass after glass of your near frozen water which goes under the name "beer." Perhaps some of your Canadian readers will get the message and start a campaign to bring real beer to your country. Anything is better than what you have, Otherwise, I loved you all!

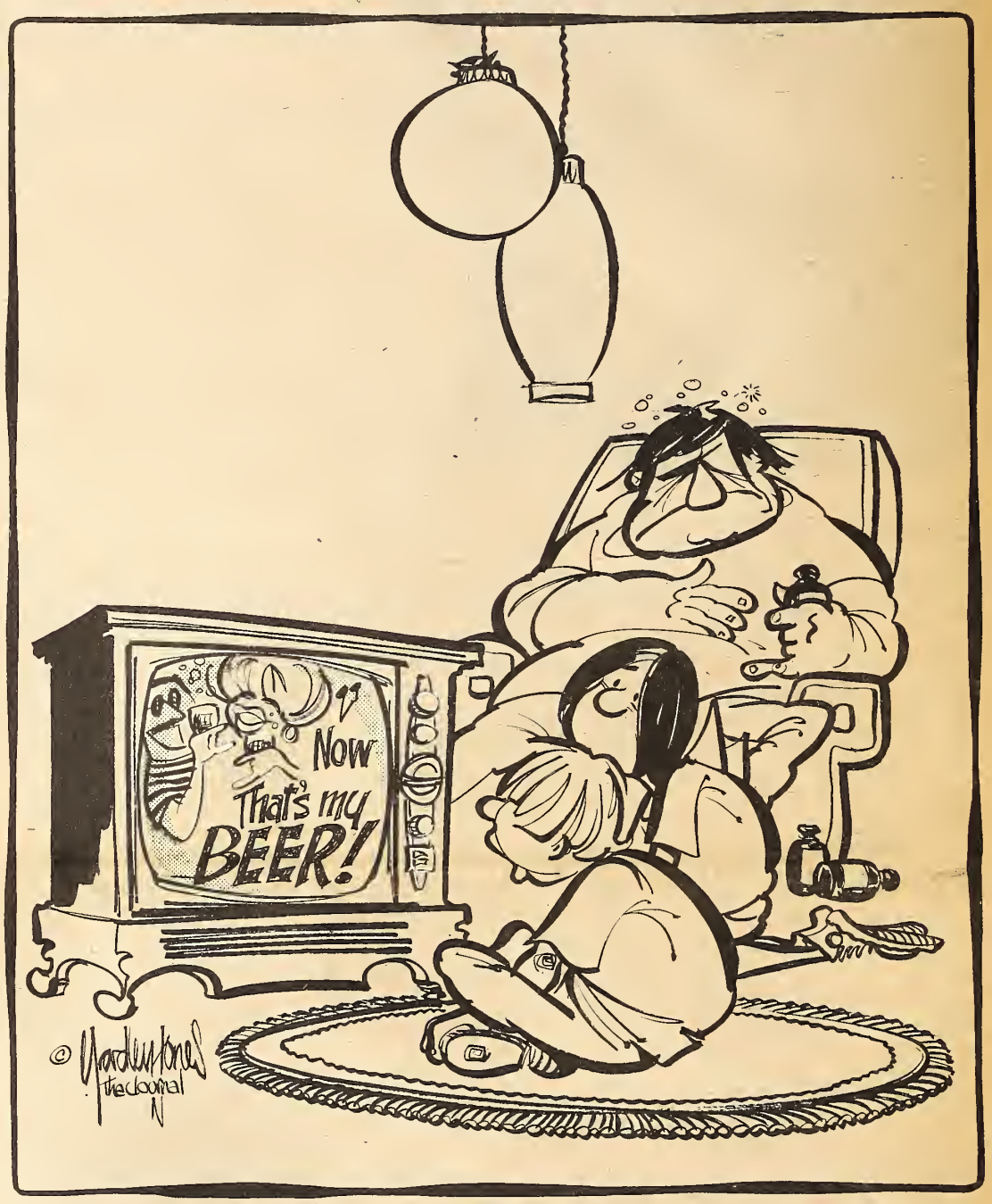
Frank Allen
Charles Close
Hove, Sussex, England

Neat letter

I was going to cancel my subscription to **The Journal** until I got the December, 1976 issue. Congratulations to Anne MacLennan and the other staff.

Neat job!

J. Leland
Reno, Nevada



'So how come they don't get busted for pushing?'

Inside Science

Why teenagers tu

By Paul Kohn*

THERE HAS been much concern about what attracts teenagers to use illicit drugs, notably marijuana which is the most popular illicit drug. Because it is evident there is no one cause for adolescent drug use, a number of fairly complex theories have developed in this area. This column is about one such theory developed and being researched by Helen Annis and myself.

The theory assumes first that people make choices about smoking marijuana (or about any other behavior) on the basis of their attitudes, or overall evaluations of the behavior. These evaluations essentially answer the question: "How desirable or undesirable is it for me to use marijuana?" The overall evaluations, in turn, are assumed to depend on people's perceptions of the personal consequences of smoking marijuana. The question here is: "What can marijuana do for me and/or to me?"

Past research suggests certain perceived consequences are particularly likely to influence attitudes and, indirectly, behavior in relation to marijuana. One such perceived consequence is peer acceptance. Smoking marijuana may be a way of making friends and influencing people, if they also happen to approve of smoking marijuana and even do so themselves.

Another perceived consequence is the symbolic expression of protest against conventional society and its norms. Marijuana may be a way of thumbing your nose against conventional authority and defying its regulations. A third perceived consequence is the acute effects of the drug. These include alterations of consciousness, notably emotional changeability, and heightened sensations (e.g. for colors, sounds, tastes, and sexual stimulations).

Fourth, there are also perceived *risks* attached to marijuana use, possibly negative consequences. These include risks to physical and mental health as well as social and legal risks.

We assume the various perceived consequences are not equally important to everybody. How important a particular consequence seems to you will depend on your personality. Thus, symbolic protest should appeal only to rather rebellious youngsters, not conservative ones. Similarly, the perceived risks attached to marijuana use should deter cautious teenagers, but not ones who are real risk-takers generally. Altered consciousness too, should appeal to particular kinds of people, namely ones who generally take pleasure in emotional fluctuations, unusual sensory experiences, and heightened perception. (We call such people "internal sensation-seekers".)

Finally, the acceptance of permissive and drug using peers should appeal most to those who themselves most resemble them, i.e. rebellious, risk-taking, and internal sensation-seeking teenagers. This is simply another instance of strong interpersonal attraction among similar peopl
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Comment

Head magazines an interesting phenomenon

By Wayne Howell

High Times, the glossy counterculture magazine dedicated to the pleasures of pot and the selling of drug paraphernalia such as water pipes and marijuana seed separators, has become in the course of a few short years, an establishment magazine.

The December 1976 issue is a full 178 pages and appears as plump and stuffed with advertisements (71 pages) as the Christmas issue of *Playboy*.

The phenomenal success of *High Times* has not gone unnoticed and just as *Playboy* spawned a host of imitators, other new glossy drug magazines have appeared over the last two years. *Head* magazine, which started as a 16-page tabloid in November, 1975, is now a full-fledged junior version of *High Times* and *Rush* magazine, which has put out three issues to date, appears to be as professionally produced as *Head*.

The content of all three magazines is depressingly juvenile but *High Times* seems to be a cut above the upstarts — and a cut above the *High Times* of a year ago. *High Times* seems to have evolved like *Playboy: Playboy* originated as a soft-porn magazine, rapidly became an institution with its own Philosophy of Life, and then eventually found itself losing readers to *Penthouse* (the magazine that brought you pubic hair) and other sex magazines which did not have a Hefnerian aversion to the kinkier aspects of human sexuality.

It is perhaps significiant that while both *High Times* and *Rush* have Santas on their respective December covers, the *High Times* Santa is merely holding a pipe — the *Rush* Santa stands beside a snow-laden spruce tree and is sniffing up some of the "snow" through a little plastic tube. Perhaps this cocaine-snorting Santa Claus on the cover is the drug-magazine-world equivalent to pubic hair.

In a way, the drug magazines fill some of the same kinds of needs as the sex magazines. That is, they are bought and read by persons who would like to be doing it all the time *or would like to be thought of as persons who are doing it all the time*, when in actual fact, if they were doing it all the time they wouldn't be bothered reading about it.

I imagine one could cut quite a raffish figure in some pubescent social circles with a copy of *Rush* under one's arm (one could, for instance, scandalize one's parents) but one could be secure in the knowledge that one could not be busted just for possession of a magazine. Thus, I am not so sure that the astounding commercial success of the head magazines is an indication of another groundswell of drug-taking any more than the purchase of millions of *Playboy* magazines in the early 1960s was an indication of rampant sexual licence at the time.

There is another way in which the head magazines are analagous to the skin magazines. They both provide material for fantasies; in the one case sexual fantasies, in the other case, drug adventure fantasies.

The head magazines are replete with first person articles written by people who have (supposedly) been involved in the international drug trade; there are exotic adventures to Katmandu, Morocco, and Mexico where the intrepid hero-dealer meets quaint old peasants who offer dynamite dope they want to share with the world. That sort of thing. The grass is always green and no-one ever gets tossed in a Turkish slammer for a decade or so.

Sex does, of course, get its due in the head magazines — often the hero, the peripatetic pot procurer, will share some of his stash with a willing chick and they will get it on, so to speak. And the advertisers of paraphernalia are not adverse to showing a little female skin in pursuit of their marketing strategy. Indeed, the ads in the head magazines tend to be raunchier than the equivalent ads in the sex magazines.

But, from an editorial point of view, the magazines are pure drug — as witnessed by the fact that both *High Times* and *Head* have centrefolds of drugs only. (It's true, I swear it, the November/December issue of *Head* sports a centrefold of Thai 'sticks' of marijuana.) I assume these centrefolds are offered tongue-in-cheek. But who knows? Perhaps they perform some useful grassturbatory function.

The head magazines are an interesting phenomenon of our times. If, as the Danish studies suggest, pornography does not produce perverts, then perhaps head magazines do not produce 'heads' and they are of little concern. All the same, I think they bear watching.

High Times, *dedicated to the pleasures of "recreational drugs" is just a cut above the upstarts, according to Wayne Howell.*

Like Rush *magazine,* Head *is trying to gain its share of readers who want to know all about dope but are afraid to ask.*

Brittle bond between funders and academics

By Larry Gage

HAVING READ with interest the Inside Science column in the December 1 issue of **The Journal**, in which Michael Goodstadt asks When is non-drug education drug education?, I feel constrained to ask: when is criticism of drug abuse education non-criticism of drug abuse education?

This subject is of more than passing interest, since the United States Senate subcommittee to which I am chief counsel will be deciding this year whether to renew or expand our own Alcohol and Drug Abuse Education Act, or perhaps to permit it to expire gracefully at the end of the coming fiscal year. To that end, we will be holding hearings, visiting programs, assessing research and evaluations, and making widespread inquiry into the nature of this beast we call "prevention" or (drug abuse) "education".

The problem is, I could not tell from the brief discussion of the subject whether Dr Goodstadt was being critical or supportive of current and future efforts in this area. On the one hand, he calls attention to the "apparent lack of effectiveness of previous informational efforts." On the other, he seems to express a rather cautious optimism about new affective developments in the field — although he admits that success may occur in programs oriented toward a broader spectrum of human behavior, regardless of the actual substance abuse "content" of those programs. He also qualifies his optimism by noting the lack of current research on which we can base any conclusions.

However, Dr Goodstadt's exhortation to await the clear solutions that will undoubtedly spring from future research and evaluation, skips several crucial steps and leaves several gaps in our knowledge. Is it meant to imply that we have lacked adequate research and evaluation techniques to assess drug education programs in the past? If so, how can we now properly assess the previous programs he so briefly dismisses? And too, how can we expect future gains from research, when the research may have as little solid foundation as the rapidly-changing education programs it is called upon to review?

Let me try to put it another way: previous techniques for imparting drug abuse education are dismissed by researchers like Dr Goodstadt because of their "*apparent* lack of effectiveness." New techniques, however, seem to show greater promise, although (or possibly even *because*) they place considerably less emphasis on drug abuse information. Of course, we don't really know that yet, because research has not yet developed adequate criteria to assess the effectiveness of drug abuse education programs in the first place.

The result, I'm afraid, appears to be a researcher's dream — and a decision-maker's nightmare. But, given that approach, how can public or private health or education funding sources, whose concern is for the most effective current allocation of scarce health and education resources, predict present and future funding needs for these ongoing programs?

I would have much preferred a column amplifying Dr Goodstadt's enigmatic statement regarding the "apparent lack of effectiveness of previous efforts" than his breathless anticipation of future intellectual inquiries into the newest educational gimmicks. For example, to whom is this "lack of effectiveness" apparent? For what reasons? In what circumstances? And, by the way, what gains are taking place in our *evaluative* sciences, so that we can hope to gain a better perspective on our new or existing drug abuse education efforts in the future?

My strong words in this matter are not directed at Dr Goodstadt personally, and indeed, I recognize that **The Journal** is a popular (not a scholarly) publication, in which academic chattiness is more acceptable than rigorous inquiry. Rather, they are an expression of my frustration at the inability of funding sources and academic researchers-evaluators, to "cohabit" effectively in the world of day-to-day delivery of health (and education) services to those who need such services in both our countries.

I have become frustrated, on the one hand, with the inability or unwillingness of too many of our politicians and bureaucrats to proceed on the basis of careful, critical evaluations of current and previous efforts. On the other hand, I have become equally frustrated with the apparent inability of so many of our researchers to understand or appreciate how important their product is to those who make public and private funding decisions involving billions of dollars a year.

I shall close this with a request — nay, a plea — for further cooperation and assistance. As I stated above, our subcommittee is now engaged in an inquiry into the effectiveness of current and future alcohol and drug abuse education programs. We hold no brief for or against any such program. Rather, we hope to come to as accurate an assessment as possible of the current state of knowledge and technique in this field. Any information or further references would be useful in making some important legislative decisions regarding future federal aid in this field in the United States.

*** Larry Gage is counsel to the United States Senate subcommittee on alcoholism and narcotics.**

urn on with marijuana

e, a well-esta- ocial psycho- ies a kind of re attitudes rceived con- titudes, and ermine the ar perceived mmarize it rugs for what l one person- personality's ted a survey ested an ear- y by getting respond to rijuana use, luences, and were gratify- earlier ver- er, to achieve we found it theory to its the fact that ts' responses at only one point in time limits the inferences that one can make. The results fit our earlier model, but do not actually prove its validity. A longitudinal study which samples participants' responses at two (or more) points in time would permit stronger conclusions. We are presently undertaking such a study based on the present version of our theory.

What value does such research have aside from keeping the investigators busy and satisfying their curiosity? The theory does have practical implications. First, it suggests that illicit drug use can serve personal needs and functions which are not illegitimate in themselves. Therefore, treatment and prevention efforts should provide alternative means of serving such needs and functions.

Second, the theory suggests the exact attractions of marijuana use may not be the same for different users. Peer acceptance may be most important for some, the expected pleasures of use for others, the unimportance of risk for still others, and even symbolic protest for a few. What program of prevention or treatment will work best for an individual should depend on what kind of a person he or she is and what particularly attracts him or her to marijuana use. We are trying to develop a sound theoretical basis for the prevention and treatment of problems associated with drug use.

If our research continues to support the theory, we can attempt to develop similar models for the use of other substances, and even to test some of the theory's implications for drug education and counselling. In the meantime, we must complete our ongoing research in the hope that it will justify these further activities.

* * *

Dr Kohn is a part-time consultant in the department of evaluation studies at the Addiction Research Foundation of Ontario. He is also an associate professor of psychology at York University.

Kids paint alcoholism as mutilating force

By Lynn Payer

STRASBOURG, France — When Alsacian schoolchildren ages 7 to 14 were given an assignment to draw pictures representing either alcoholism or sobriety, most chose to represent the dangers of alcoholism.

And automobile accidents were by far the most frequent theme, the IV National Congress against Alcoholism was told here.

That alcoholism is a source of anguish for children of this age group was apparent in the thick lines and frequent use of red, brown, and black in their drawings, said Ms Claudine Sfar, a psychologist.

Children seemed to be very sensitive to effects of alcohol on the body, and it was often represented as a mutilating, surgical force, a frequent theme being an operating room. Cirrhosis, however, was a very rare theme of the designs, Ms Sfar said.

Other interesting aspects of the designs were:

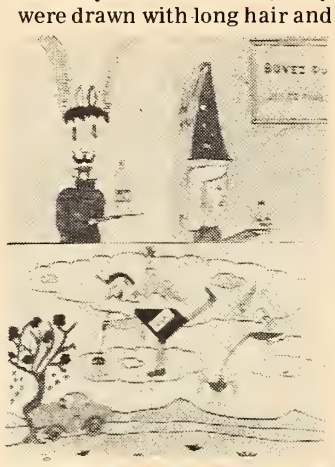
• Alcoholics were almost always represented as males, often resembling clowns. Particularly in rural areas, they were drawn with long hair and beards.

• Alcoholism was usually represented on the left-hand side of the paper with sobriety on the right, indicating that children view alcoholism as regressive.

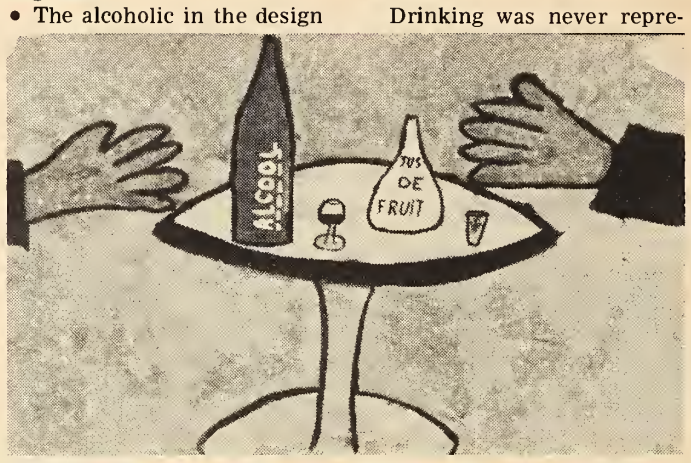
• The alcoholic in the design was often shown in a cafe surrounded by signs, a bartender, or friends, urging him to drink. "Children understand quite well the importance of these exterior urgings," said Ms Sfar.

Drinking was never represented, however, at family celebrations even though drinking on such occasions is very common in Alsace, she said.

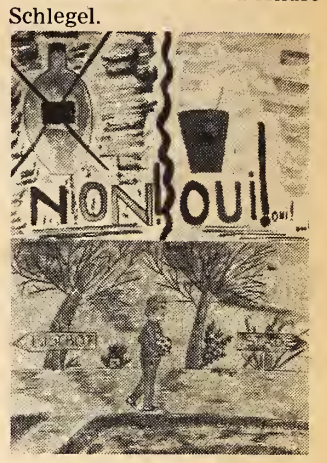
Ms Sfar's co-workers were Francois Marcoux and Andre Schlegel.



Alcohol is represented as a monster, sobriety as a fairy.



Alcoholism is represented generally on the left-hand side of a picture, and sobriety on the right.



Thick contours of the design indicate anguish.

Pictures were on display at the IV National Congress Against Alcoholism.

'Severe winters drive Canadians to drink'

Britons get message to adopt healthy habits

By Thomas Land

LONDON — Britain's hard pressed Labour Administration, currently under intense international pressure to reduce government spending on social services, has announced its intention to allocate an extra £1 million during 1977 to the national Health Education Council which is concerned primarily with alcoholism, drug abuse, smoking, and related problems.

The announcement was made by David Ennals, secretary of state for social services, while a team from the International Monetary Fund was visiting London negotiating cuts in government spending as a condition to granting a huge loan requested by Britain to support its declining currency. Mr Ennals' announcement is therefore interpreted as a statement of the Administration's priorities.

It follows a report issued by the influential National Council of Women (NCW) demanding just such a measure.

Addressing the annual meeting of the Society of Family Practictioner Committees, Mr Ennals explained: "This extra money will help the Health Education Council to give a stronger national lead. New projects the council is considering include measures to instil more positive attitudes to healthy habits, a scheme to promote the training of more health education officers, and a regional campaign on alcoholism.

"What are the key messages which we need to get across?

"The first is to cut down on cigarette smoking. It is not just doctors but also other professional and managerial people who are smoking less. But male manual workers are still smoking as much as ever. And more women are smoking more than ever before. Can't we at least persuade youngsters not to take up the habit and to cause useful disruption in the home by criticizing their parents' smoking habits?

"The second message is, of course, about drink. There is an alarming increase in alcoholism, particularly among young people. And this, as we all know too well, is associated with death on the roads. . . The human body is not like a car which can always be repaired, if at a cost. We only get one chance — one body."

The NCW report, which may have triggered Mr Ennals' announcement, made three additional major demands:

• Instruction about alcohol in the health education curricula of schools and colleges of education;

• Establishment of a permanent national commission on alcohol affairs;

• And systematic research into the economic cost of problems arising from alcohol abuse.

The document, *Alcohol Problems of Women and Young People*, (National Council of Women, 36 Lower Sloane Street, London, SW1 8BP, England, 40p), was compiled by a working party supported by the Health Education Council with a grant and research assistance.

Set up 18 months ago, the working party called for publicity campaigns to increase public awareness of the dangers of alcohol abuse causing "grave physical, mental, social, and economic problems".

"Women have jobs as well as families, and they are expected to give their individed attention to both," the report says. "They can't, so they crack."

It estimates that roughly 150,000 of Britain's 500,000 alcoholics are females, more than twice the proportion of a decade ago.

It also blames the size of the problem on "increased affluence, more leisure and the new independence won (by women) in recent years" as well as on women's greater proneness to alcohol addiction. And it urges the Administration to mount a national anti-alcoholism campaign similar in scale to the campaign against smoking.

In a world survey on alcoholism, the authoritative *Sunday Times* newspaper here reports that in 1975, Britons consumed the equivalent of 8.1 litres of pure alcohol per head — up from 6.4 in 1970 — amounting to, say, three bottles of scotch or gin, nine bottles of wine, and 206 pints of beer. The new total made Britain the nineteenth most alcoholic nation in the world.

The second place in the "spirits league", surprisingly, went to the Japanese. But, the newspaper comments, "even more puzzling is the leap of the Canadians from relative obscurity to third place in spirits consumption, only just behind Japan. Their favorite spirits are dark rum and rye whisky which they drink chiefly to fortify themselves against the cold. One theory is that the increase is merely a reaction of the severity of the past few winters in Canada.

"Outdrinking both the Canadians and the Japanese are those most determined of hard liquor drinkers, the Poles, who on average consumed almost 10 bottles of spirits in 1975. Their consumption is still increasing."

Norway's tobacco ad ban has promising beginning

LONDON — Adult per capita consumption of cigarettes and smoking tobacco has dropped by 2.7% in the first year of Norway's total ban on tobacco advertising.

Dr Kjell Bjartveit, chairman of the Norwegian National Council on Smoking and Health, said while this and other figures on smoking reductions are promising, "they do not prove any causal relationship to the introduction of the Tobacco Act.

"To my mind, the restrictions will essentially have an influence upon young people who have not yet acquired the habit. Hence, it is clear that changes in smoking habits will appear gradually, as new generations are replacing older people and their heavier smoking.

"Only long-term trends will make it possible to judge about this difficult question."

However, the indications are there, he told a conference on smoking and the media organized by Action on Smoking and Health here, and therefore: "Do not sit on the fence waiting for more results of the Norwegian Experiment.

"In stemming the great epidemic of modern times, there is no time to lose."

Dr Bjartveit said the Tobacco Act, which came into force on July 1, 1975, followed several years of debate. It is not an isolated act but part of an integrated program of warning and education on the dangers of smoking.

The act is simple and states only: "Advertising of tobacco products is prohibited." There is leeway for change by the King in Council, if it is found at a later date, for example, that tobacco products may be produced which do not have a health risk.

Every pack of cigarettes has a symbol and text pointing out the health dangers associated with cigarette smoking. No person under the age of 16 may buy cigarettes.

Dr Bjartveit said since introduction of the act the tobacco industry and retailers have largely been loyal to its provisions. Ridicule has come from some newspapers but this is tempered by strong support from others.

Cigarette consumption has been consistently monitored by the Central Bureau of Statistics in cooperation with his council since two years before the act came into force.

Some of the latest figures show that among males, the percentage of daily smokers went down from 52% in June, 1975, to 48% in December.

Average consumption among male cigarette smokers went down from 14.4 cigarettes per day in June to 13.2 in December.

There was no significant change in the percentage of daily smokers among women in the same period but it seems the increase in their smoking has reached a plateau.

In the Oslo area, changes have been particularly pronounced, Dr Bjartveit said, but only among males. In June, 1975, 60% were smokers. This dropped to 54% in September and to 45% in December.

Dr Bjartveit pointed out: "Nobody has expected the Norwegians would change their smoking habits overnight, due to the Act."

NZ in sticky wicket

AUCKLAND, NZ — Cricket has now joined the several other major New Zealand sports sponsored by tobacco interests. Over the next five years, the sport will receive more than $95,500 from the Rothmans Sports Foundation.

To David R. Hay, secretary of the scientific committee of the National Heart Foundation, "going the tobacco way" just isn't cricket.

"Surely," said Dr Hay, "the sports administrators can see that this is simply Rothmans' way of getting its name before the young who will shortly be a major market for the industry."

Babies hurt by mothers' smoking

AUCKLAND, NZ — Children whose mothers smoked were found to have significantly reduced IQs in a New Zealand study of long-term effects of perinatal hazards.

"The effects of smoking were quite dramatic," said Barton A. MacArthur, senior lecturer in education at Auckland University.

The study, on 240 children of low birth weights, began in 1968. Intelligence and other assessments were conducted pre-school (at 4 years 9 months) and in school (at 6 years).

The average IQ of children whose mothers smoked during pregnancy was 97.8. The average for the children of non-smokers was 105.1.

The difference reached the p0.001 level of statistical significance. A similar level of difference was found when smoking before pregnancy was studied.

Children whose mothers smoked before pregnancy had an average IQ of 97.2. Those whose mothers did not smoke averaged 105.9.

Whisky is excellent for self-manipulation

Alcohol information may create desire to drink

By Lynn Payer

PARIS — Information about alcoholism may actually increase alcohol consumption rather than decrease it, Michelle de Vulpian, Director of Studies for COFREMCA, an applied social science and marketing study organization, has said here.

Ms de Vulpian has carried out several studies for the Comité National de Défense contre l'Alcoolism. The latest was aimed at discovering what situations cause people to take a drink. She said that during the studies most of the people working on them, including herself, found their consumption of alcohol increasing.

People interviewed in their homes about their drinking habits quite often offered the interviewer alcoholic drinks, something that is rare in most interview situations, Ms de Vulpian said.

And while she was compiling the data, she often found herself on the way to pour herself a whisky at a time of day when she normally wouldn't have.

"Luckily, I stopped myself or the report would never have been finished," she said.

In the latest study, 40 people falling between the extremes of those drinking very little and frank alcoholics, were interviewed in depth about their drinking. Some of them were provided with tape recorders and instructed to dictate into them every time they wanted a drink. This information was supplemented by a questionnaire given to 1,000 people representative of the French population.

One of the striking findings of the study was that, according to Ms de Vulpian, "an incredible amount of alcohol is consumed without any particular motivation to drink."

"We were very much struck by the large quantities of alcohol ingested during the day and the week by habit, routine, hospitality rituals, and politeness without strong motivations to drink," she said.

"People could rather easily become alcoholic without ever having had terrible problems."

Motivations, when they did exist, were often contradictory. People drink because they're happy and because they're sad. They drink to keep from being too happy and to maintain sadness.

People in positions of responsibility drink because of the responsibility and the unemployed drink because they're unemployed. People drink because they feel guilty about their drinking.

"It's as if alcohol is a response to a number of stimuli that may be contradictory, or at least very different. One drinks to maintain a state of tension, whether this state is positive or negative — or to break another state of tension, which can also be positive or negative."

People thus drink to manipulate their own moods, and most are rather good at manipulating within the right limits: a definite value is placed on knowing one's "dose" and not exceeding it. At a party, for example, nearly everyone reaches the same level of euphoria. If the euphoria wears off for one of the party-goers, he is obliged to drink again so that the others don't seem unbearable.

Three-fourths of the people, particularly the heavier drinkers, set some type of limits to their drinking, whether this was not to drink whisky, not to drink on an empty stomach, not to drink every day or, particularly for those in intellectual occupations, not to drink before a certain hour in the evening.

"If you offer a drink among certain classes in France now, the first thing most people do is to look at their watches," Ms de Vulpian said.

In reality, the limits if they are respected, serve mostly to silence the drinker's conscience, she said. They are usually set high enough that the person can drink all he wants without exceeding them, and they tend to increase with time.

Whisky is the drink *par excellence* for self-manipulation, because few people seem really to like the taste and they find this reassuring.

"I had one teenager explain to me that she wasn't worried because all she drank was whisky, which she didn't like. What *was* disturbing her was that she was beginning to show a preference for certain brands.

"Before, in France, when people drank wine and cognac there was at least a pretence of being a connoisseur, although it was probably masking other things. Now the French — and particularly those groups that tend to be the trend-setters —admit that they take their alcohol like medicine."

People who don't drink are often those who tried to manipulate their mood with alcohol but failed, either because they got out of control and became an object of ridicule, or they got sick.

This finding has made Ms de Vulpian skeptical of the Alcoholics Anonymous doctrine that it is the alcoholic who has a special biochemical reaction to alcohol.

"While this doctrine is valuable in that it takes the moral stigma away from alcoholism, our results tend to indicate that it's the non-drinker that has the special sensitivity to alcohol and it's the healthy people who become alcoholics."

She stressed that special techniques must be used when interviewing people about their alcohol consumption because of the guilt attached to drinking, which will be stronger in those who drink the most. This will cause heavy drinkers to minimize their drinking the most, whereas moderate drinkers will be more honest, leading possibly to results that are the exact contrary of the reality.

For example, most of the interviewees denied they drank much, but when they were asked what they had to drink the day before, it was a significant amount. Similarly, they denied drinking alone, but when the interviewer got to the specifics, most had in fact been drinking alone.

As another technique, the interviewer often broke the ice by confessing his own worries about drinking too much. Still another device, particularly with teenagers, was suddenly to ask them to tell about their last drinking spree, "and they'll tell you all about it, contradicting everything they said in the earlier part of the interview."

If just hearing the word alcohol makes heavy drinkers want to drink, does this mean that public information campaigns about alcoholism are doomed to failure?

Not necessarily, said Ms de Vulpian, but she stressed such campaigns are delicate. A common mistake, she said, is to call attention to the more sordid aspects of alcoholism and to stereotype the alcoholic as the bad father, the skid-row bum, or the man who beats his wife. She cited, as an example, the anti-alcoholism slogan used in France — a play on words meaning that when the parents drink the children suffer.

"The more people drink, the more they need such stereotypes because they can rather easily say, 'that's not I'." Similarly, she said talking about the risk of cirrhosis is not very effective because cirrhosis is something that happens to other people.

What does tend to work, she emphasized, is pointing up the day-to-day consequences of drinking.

"You can say alcohol causes accidents. That works. You can say one feels much better without alcohol. That works."

One of the most effective arguments, she said, is that alcohol is fattening.

"One of the few people we interviewed who had stopped drinking was a man who was on a spring diet in preparation for summer beaches.

" 'I have two spare tires. One I call Black and White and the other Johnny Walker', he explained."

First major campaign in several years

UK drunk drivers under renewed fire

By Thomas Land

LONDON — Britain has launched a new $840,000 publicity campaign intended to reduce the incidence of drunken driving, a major and growing source of traffic accidents.

John Horam, the parliamentary under-secretary of state at the Ministry of Transport said: "This is the first major campaign in several years to alert drivers to the dangers of drinking and driving.

"At the time of the 1967 Road Safety Act, which introduced the roadside breath test, there was a 34% reduction in late evening casualties and a 50% reduction in the number of fatally injured drivers who were over the legal limit (of alcohol consumption).

"Much of this advance has since been lost," he went on, "and in fact, the situation is in many ways worse now than ever — 35% of drivers killed in accidents are over the limit, compared with 25% before the 1967 Act."

The Labour Administration recently announced its acceptance of recommendations put forward by the Blennerhassett committee of inquiry (**The Journal**, August, 1976) seeking legislative changes, including stiffer penalties, to reduce the frequency of drinking offences by drivers.

Legislative proposals along these lines are expected to be put forward by the government this year. Among other things, the committee sought periodic major publicity campaigns to renew public awareness of the drinking-driving problem. Hence the present campaign.

The new campaign is called "Don't Take your Car for a Drink". It began in December and may run until the end of March.

There are three 45-second television commercials, two of which show dramatically how drinking as a social activity can lead to disaster; the other depicts actual case histories of people penalized for drinking and driving. A 60-second cinema commercial specifically directed at young audiences is also being shown on television, exploring the way a young driver's reaction can be dangerously impaired by social drinking.

Initially limited to cinemas and television, the campaign will be extended this month and next to include posters and hoardings, bus backs and multi-story car parks.

It will also produce an interesting opportunity for sociological surveys. The campaign will cover parts of England, Scotland, and Wales — except the Tyne-Tees and Yorkshire television areas which have been omitted from the program to enable social scientists to make subsequent comparisons on its effects in terms of drivers' attitudes, actual behavior, and accident rate.

The committee of inquiry into drinking and driving offences pointed out that one of the chief reasons for the worsening situation was that thousands of young drivers had qualified since the passing of the 1967 Road Safety Act and that little had been done to educate them about the problem.

Mr Horam said that "over half the deaths of drivers over the limit, and of drinking and driving convictions, are among drivers under 30 years of age. This campaign is therefore specifically aimed at younger drivers.

"But I would emphasize," he went on, "that the problem is not confined to that age group. There is a responsibility on all of us to be extremely careful about drinking if we are going to be driving afterwards."

Beer brewed for drivers

LONDON — Plans by a major independent brewery in the north of England to introduce a low-alcohol lager for drivers has run into a mountain of criticism by automobile organizations and other groups.

Greenall Whitley, which owns 1,500 pubs, said it has already test-marketed its low strength lager and customers found it acceptable. It claims drivers may drink up to eight pints and still pass the breathalyzer test.

The Automobile Association immediately called the plan irresponsible. A spokesman added: "This brew can be encouraging people to drink and can give them the wrong sort of over confidence."

Around the World

Soul saving

A Tel Aviv rabbi says smoking is bad not only for the health, but for the soul. Rabbi David Halevy says smoking or offering a cigarette to another is a violation of Jewish law which prohibits any drugs that might cause bodily harm. Smoking is widespread in Israel, however, and many member of the Israeli cabinet have developed the habit. Former Prime Minister Golda Meir is a chain smoker, but always stubs out her cigarettes before being photographed because she says she doesn't want to be a bad influence on children.

Snooker

To raise money for the Anchorage Christian Rehabilitation Centre he runs in Hamilton, New Zealand, Paul Phillips challenged the world non-stop snooker playing record. He stopped after 100 hours, 24 hours better than the previous record, with sore back and feet, a strong desire to sleep, and more than $8,500 raised for the centre, which works with drug addicts and alcoholics.

State control

Legal production and distribution of marijuana in Italy under state control has been called for by the small Radical Party, which has four deputies in parliament. The party said there should be an age restriction on marijuana purchases similar to the system used for the sale of alcohol in Scandinavia.

Down under

Australia's Director-General of Health, Gwyn Howells, has called for a change in community attitudes towards alcohol consumption. In his annual report, Dr Howells quoted the latest statistics which show that in 1974-75 Australians drank 1,922 litres of beer, 168 million litres of wine and 16 million litres of spirits. That works out to 142.66 litres of beer, 12.47 litres of wine and 1.21 litres of spirits per person.

Case dismissed

Discharging a man accused of charges arising from cannabis transactions, a New Zealand Supreme Court judge said the deals took place only because of the "persistent encouragement" of an undercover policeman. The court heard that the police officer also completely financed one deal by providing more than $20,000 of official funds.

Sick days

Despite the British government's tardiness in applying measures to counteract the nation's harmful smoking and drinking habits, the government is now insisting preventive health education can do much to improve the quality of life and save the country money. Minister of State for Health, Roland Moyle, said Britain lost 325 million certified days of sickness, invalidity, and industrial injury in 1974-75, and added that preventive measures could do much to reduce the "appallingly high figure."

Many alcoholics are chronic depressives first

By Manfred Jager

WINNIPEG — There is a false belief that depression is more common in women than in men. In fact, alcoholism masks the truth.

John Varsamis, associate professor of psychiatry at the University of Manitoba, said in an interview with **The Journal** the belief is "about three depressed women to one depressed man. But alcoholism is more common in men.

"So the feeling is that depressed men drink, and we call them alcoholics, while depressed women don't drink as often, so we treat them as depressions.

"It's not really a true difference in the incidence of depression. It's simply a matter of drinking and a matter of women not drinking as much as men. Fewer women will drink as much as men and present as alcoholics."

Dr Varsamis said that there is increasing evidence that a significant amount of alcoholism might be caused by severe chronic depression rather than the other way around.

Once diagnosed and treated, the depressions of alcoholism can be dealt with. The reason for alcohol abuse is then removed and alcoholics may make complete and permanent recoveries.

Dr Varsamis estimated liquor problems relate to depression in about 20% of patients, "and that's a very cautious estimate".

The trouble is physicians have such a difficult time identifying the connection, as many alcoholics have masked their depression for years by either being drunk or craving to be.

Dr Varsamis, of the University of Manitoba medical school and Winnipeg's Health Sciences Centre and Grace Hospital, said organizations such as Alcoholics Anonymous have so far failed to recognize the growing evidence of the connection between depression and alcoholism.

"Most doctors are not recognizing it either," said Dr Varsamis.

"What usually happens is that somebody comes in who is drinking heavily, and it's very hard to tell whether he or she is depressed, because they have been heavily intoxicated for such a long time the underlying symptoms are masked.

"So we dry the patient out, and then, after a period of time, we discover he is suffering from depression, often dating back a number of years. Or we see an alcoholic who has been dry for some time and thus discover that depression was what originally started him drinking," said Dr Varsamis.

"People are depressed, they drink to get over their depression and eventually, after some considerable time, they become alcoholics."

Most severe chronic depression occurs in people who pursue careers, have an acceptable standard of living, and often are quite successful, Dr Varsamis said. This also makes it more difficult to identify a depression underlying a problem with alcoholism.

"We find that if these depressions have not gone on for years, they have at least been of an episodic nature," the psychiatrist added.

How to intercept the vicious circle of depression and alcoholism?

"The first problem is to recognize it," said Dr Varsamis. "All we can do, really, is treat somebody as an alcoholic until he sobers up and stays sober for long enough to allow us to search for underlying causes for his alcoholism."

Dr Varsamis said one of his patients, an alcoholic, stayed sober for 15 years, then went into a drinking bout — "and suddenly we discovered there was a depression there that triggered the drinking".

Dr Varsamis said family studies of depressives and alcoholics have shown that the male relatives of a diagnosed alcoholic tend to drink, while the female relatives are more likely to suffer from severe chronic depression.

"We suspect that the patient who is drinking also suffers from depression and drinks for that reason."

When families of depressives were studied, on the other hand, it was found that male relatives tended to be alcoholics and female relatives tended to suffer from depression also.

The psychiatrist said clinical studies have shown that treating depression with lithium will have therapeutic effects on both the patient's depression and his alcoholism by removing the psychological need to drown sorrow in liquor.

Organizations such as Alcoholics Anonymous, Dr Varsamis said, are therefore incorrect in their uncompromising opposition to all drug therapy.

Chemical agents such as lithium, administered under medical supervision, should be excluded from the AA philosophy — "and we are beginning to get this message across now, I think."

Ultimately, the only effective way of dealing with society's alcoholism problem is prohibition, Dr Varsamis said.

And while there is a widely-held opinion that prohibition did not work where it was imposed during the early years of this century, Dr Varsamis said medically speaking it did work.

"There was far less alcoholism around during those years. Doctors seldom saw delirium tremens, cirrhosis of the liver was down, and so were other conditions primarily related to alcoholism — despite the fact that those who wanted to consume alcohol could find a way of having a drink at a party or in a restaurant with dinner."

Dr Varsamis added: "I can't see any real breakthroughs. The problem is that alcoholism is caused by alcohol, and you'll have to deal with alcohol.

"It's like trying to do something about heroin addiction, but at the same time having government push heroin with an official heroin control commission marketing the stuff to the public, and making a lot of money with it. How can you stop that?"

NIDA not the roadblock researchers claim

Pot therapies under study

WASHINGTON — The US National Institute on Drug Abuse is not the roadblock to the study of marijuana's medical value that many researchers claim. In reality, according to Robert Peterson, PhD, it supports dozens of projects.

Dr Peterson, was making a spirited defence of his institute from the floor of the conference here of the National Organization for the Reform of Marijuana laws. He said recent contributions include a clinical conference on marijuana, and a newly published book outlining the government role in research.

"Its role has hardly been nonexistent, and it has been an active and consistent role from the beginning of the discovery that the drug has therapeutic effects."

Publicity about young glaucoma patient Robert Randall, who now receives marijuana from NIDA, obscures the fact that the institute has been involved in a lengthy research project at University of California, Los Angeles on intraocular pressure: a number of patients there receive marijuana for their condition.

Dr Peterson said a major question is whether there is a rapid tolerance to marijuana "and therefore certain therapeutic effects may not be consistent in chronic conditions."

Glaucoma is more common in the elderly and tachycardia becomes an important consideration. Research has shown "implications for cardiac patients may be a bit more serious than they are for normal healthy young volunteers."

Dr Peterson said NIDA is in something of a dichotomous situation:

"If a drug is rapidly approved, and then the drug proves to be hazardous, not only are the physicians subjected to the possibility of suits for malpractice, there is also the fact that we in government are accused of being pawns of the pharmaceutical industry.

"That happens to be a fact, whether you like it or not.

"If it is not approved, we are then insensitive to therapeutic need."

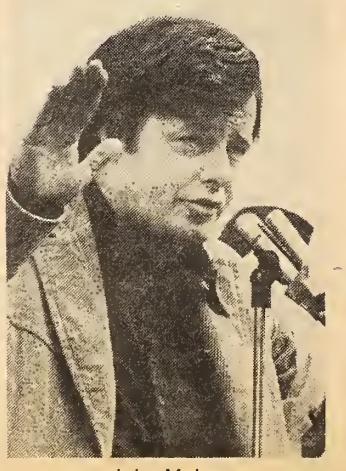
Thomas Ungerleider, associate professor of psychiatry at UCLA, told the conference: "What we do have are many friends in NIDA, FDA (Food and Drug Administration), and even DEA (Drug Enforcement Administration), who are trying to be helpful and have to count on us for some outside kinds of help. This is extremely important because of the new administration."

Best talents wasted begging for money

CLEVELAND — Most drug treatment programs are designed to fail, John Maher, director of the Delancey Street Foundation in San Francisco, told a drug abuse seminar here.

The reasons, said Mr Maher, include lack of money, lack of interest, and trying to rehabilitate addicts who "can't be rehabilitated anyway."

"Too often, the best talent in the program has to be used to beg for money, to fill out government reports, and to juggle figures to show how good a program is," he charged.



John Maher

This means there is little time and interest left to help the addict, he told the seminar sponsored by Community Action Against Addiction.

Because there is limited time and money, he said, what there is should only be used for addicts with the best prospects for recovery.

In his generally critical keynote speech, Mr Maher also criticized those who treat drug addicts, saying that many of them were "inadequate, and their programs were 'ripoffs'."

He said there is a need for economic moves to cure the evil of drug addiction, since in his view drug addiction is largely the result of poverty. For that reason, he said, the Delancey Street Foundation is running several profitable businesses which support the drug rehabilitation and education programs.

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CUT THIS ONE AND MAIL

New Books

by RON HALL

Acute Drug Abuse Emergencies: A Treatment Manual

. . . edited by Peter G. Bourne

Originally intended for the practicing physician, this guide for dealing with basic drug-related problems is not aimed at rehabilitation, but rather at the treatment of the initial stage where knowing the correct method can be crucial to recovery. Some 41 physicians with expertise in particular areas were asked to describe their preferred treatment methods which have been categorized under the following topic areas: differential diagnosis; emergency treatment of opiate overdose; treatment of acute CNS depressant emergencies; emergency treatment of adverse reactions to CNS stimulants; hallucinogenic drugs; cannabis derivatives; inhalation psychosis; acute alcohol intoxication; as well as other special problems.

(Academic Press, 111 Fifth Ave, New York, NY, 1976. 379p. $16.50.)

Alcoholism, Its Causes and Cures: A New Handbook

. . . by Harry Milt

This book is intended for both professionals working with alcoholics, conducting research, or teaching, and for those who are interested in alcoholism for personal reasons. The author challenges myths and presents evidence that the alcoholic is not a hopeless victim and that, in fact, some alcoholics can return to normal drinking. He considers such areas as; alcoholism in women, the employed alcoholic, how alcohol affects behavior, the development of alcoholism, heredity, ethnic and cultural influences, and various treatment methods.

(John Wiley and Sons Canada, 22 Worcester Road, Rexdale, Ontario, M9W 1L1, 1976. 164p. $8.95.)

Alcohol: The Crutch that Cripples

. . . by Brent Q. Hafen

The author draws on research of the NIMH and NIAAA in order to promote an understanding of alcohol use and abuse in the United States. With the aid of tables and figures, and using some point form notations, the many topic areas are covered concisely under major chapter headings which include: effects of alcohol on the body; alcohol-related behavior; social problems; treatment and prevention; and laws and regulations. A discussion of acute alcohol emergencies is included as an appendix.

(West Publishing Company, 50 West Kellogg Blvd., St. Paul, Minnesota, 55102. 1977 238p.)

Other Books

Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse. Book 3: Implementation and Resources — Schaps, Eric, Adams, William T., and Resnik, Henry S. Prevention Materials Institute Press, Lafayette, 1976. 192p $4.95.

Research Advances in Alcohol and Drug Problems: Volume 3 — Gibbins, Robert J., Israel, Yedy, Kalant, Harold, Popham, Robert E., Schmidt, Wolfgang, and Smart, Reginald G. (eds). John Wiley and Sons, Toronto, 1976. Tobacco smoking and nicotine dependence; caffeine as a drug of abuse; psychiatric syndromes of the nonmedical use of drugs; drinking patterns; cannabis and driving; prescribed psychotropic use; deaths in amphetamine users; behavior modification; nonabstinent drinking goals; sex differences in criminality among drug abusers. 476p. $31.05

Heroin Addiction: Theory, Research and Treatment — Platt, Jerome, J., and Labate, Christina. John Wiley and Sons, Toronto, 1976. Historicolegal context of heroin addiction in the US; physiology and pharmacology; theories; treatment; appendexes, references, indexes. 417 p. $11.35.

Drinking — Weiner, Jack B. W. W. Norton and Company Inc, New York, 1976. "A three-year investigation of one of America's biggest killers." 241p.

Progress in Psychiatric Drug Treatment: Volume 2 — Klein, Donald F., and Gittelman-Klein, Rachel (eds). Brunner/ Mazel Publishers, New York, 1976. Affective disorder; schizophrenia; child psychopharmacology; beta-blockers; geriatric psychopharmacology; anxious states. 653p.

Positions Available

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Detox Workers Training Program — Feb 7-11 and March 7-11, 1977, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, 33 Russell St, Toronto, Ont., M5S 2S1.

Health Research Ontario — March 4-5, 1977, Toronto, Ontario. Information: Bill Gilliland, Addiction Research Foundation of Ontario, 33 Russell St, Toronto, Ont., M5S 2S1.

1st International Congress on Toxicology — March 30 - April 2, 1977, Toronto, Ontario. Information: Robert G. Burford, G. D. Searle and Company of Canada Ltd., 400 Iroquois Shore Rd, Oakville, Ontario.

INPUT 77: 2nd National Conference on Occupational Alcoholism and Drug Abuse — May 1-4, 1977, Ottawa, Ontario. Information: Phyllis Buirds, Humber College, Conferences and Seminars, Centre for Continuous Learning, PO Box 1900, Rexdale, Ontario, M9W 5L7.

The Canadian Medical Association and Quebec Division Annual Meeting — June 19-24, 1977, Quebec City, Quebec.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections 1977, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference Headquarters, c/o The Portage Institute, 3418 Drummond St, Montreal, Quebec.

US

2nd National Conference on the Impaired Physician — Feb 4-6, 1977, Atlanta, Georgia. Information: Department of Mental Health, American Medical Association, 535 N. Dearborn St, Chicago, Illinois, 60610.

American Society for Pharmacology and Therapeutics — March 24-25, 1977, Dallas, Texas. Information: American Society for Clinical Pharmacology and Therapeutics, 1718 Gallagher Rd, Norristown, Pennsylvania, 19401.

National Association of Black Social Workers 9th Annual Conference — April 6-9, 1977, New Orleans, Louisiana. Information: Family Service Association of America, 44 East 23rd St, New York, NY, 10010.

American Orthopsychiatric Association 54th Annual Meeting — April 13-16, 1977, New York City. Information: The American Orthopsychiatric Association, Inc, 1775 Broadway, New York, NY, 10019.

National Council on Alcoholism-American Medical Society on Alcoholism 8th Annual Medical-Scientific Meeting — May 2-4, 1977, San Diego, California. Information: Frank A. Seixas, National Council on Alcoholism, 733 Third Ave, New York, NY, 10017.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC — 1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

American Medical Association Annual Meeting — June 18-23, 1977, San Francisco, California. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illinois, 60610.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Center, McLean Hospital, 115 Mill St, Belmont, Massachussetts, 02178.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse and Smoking" — July 27-29, 1977, Seattle, Washington. Information: Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, Seattle, Wash. 98195.

1st International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation, Inc, 222 E. Redwood St, Baltimore, Md, 21202.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, Ariz, 85010.

Abroad

Cruising Medical Seminar on Alcoholism — Feb 26 - March 5, 1977, Carribbean cruise aboard Cunard Countess. Information: Center for Alcohol Studies, Medical Building, 207-H, Chapel Hill, North Carolina, 27514.

6th International Conference of the World Union of Organizations for the Safeguard of Youth — May 31 - June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28 Place Saint-Georges, F-75442, Paris, Cedex 09, France.

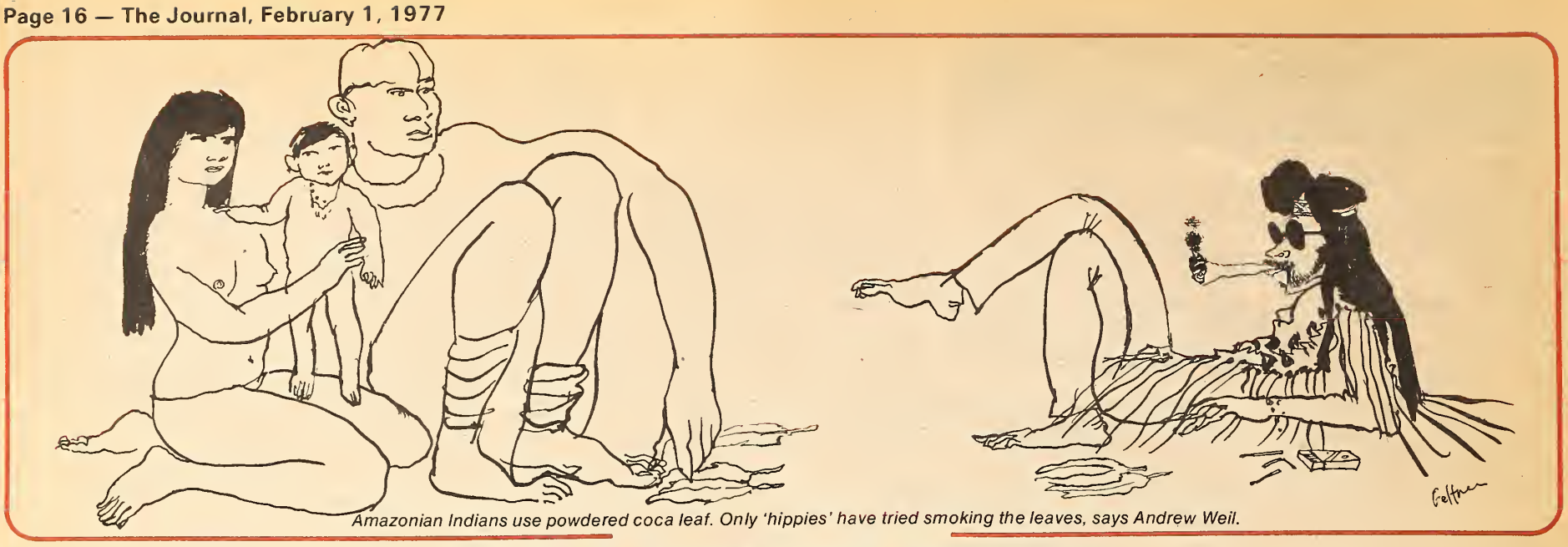
23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic, Information: International Council on Alcohol and Addications, Case Postale 140, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28 - Sept 1, 1977, Tokyo and Kyoto, Japan. Information: ICAA. Case Postale 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28 - Sept 1, 1977, Bergen, Norway. Information: Peter Nathan, department of Psychology, Rutgers University, New Brunswick, New Jersey.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.



Amazonian Indians use powdered coca leaf. Only 'hippies' have tried smoking the leaves, says Andrew Weil.

He's a passionate advocate

Weil's case for the coca leaf

By Harvey McConnell

TUCSON, Arizona — Man's infinite ability to take good and make evil is neatly illustrated in Andrew Weil's great interest in South American coca leaves, from which comes cocaine.

As a doctor, he knows from personal observation among Indians of the Amazon, and his own trials with non-Indians, the medical efficacy of coca leaves in a variety of conditions.

As a pharmacologist, he has seen severe adverse effects of prolonged cocaine use among expatriate Americans.

As a realist, he knows he cannot import coca leaves into the United States without a change in the law. This change would make cocaine cheaper and more available.

Dr Weil believes the great good that can come from coca leaves will outweigh the temporary increased availability of cocaine.

One of his objectives would be "to try and teach people why it is better to use coca rather than cocaine. I don't believe in the principle of trying to deal with these problems by denying access to the drug."

Dr Weil is among a small band of medical and legal experts who have started work to try to change the law. Many of them believe that as cocaine use is now in vogue among the American middle class, and that as they have the political muscle, change may be rapid.

Dr Weil who is also an author and authority on drugs, is currently engaged in the study of transcultural pharmacology, which ties in directly with his interest in coca leaves.

He has spent more than 18 months working in Peru, Bolivia, Ecuador, and Colombia and believes coca use there "combines the function of chewing gum and coffee in our society, and for many people has little more significance than that."

Coca comes from a perennial plant that has a long life, grows to over 20 feet, and can be harvested several times a year. The plant is sensitive to cold and could never be grown in North America.

It is also of great economic importance to the Indians. "I have seen coca growing out of soils where nothing else would grow on a commercial scale."

Dr Weil points out that most of the published work on coca leaves is based on observations of Indians who live in the high Andes, in a cold climate, and where food is scarce.

But this information about coca use is deficient, he says, because the majority of Indians who use it live in the Amazon river basin where the climate is hot and there is adequate food.

Some of the studies of coca use have been "quite shoddy." A particular one which draws his invective was by scientists who attempted to administer a battery of sophisticated American psychological tests and concluded that coca leaves lead to impaired intelligence among Indians living in the Andes.

The Indians living high in the mountains put dried coca leaves into the mouth, build up a wad, and then suck the juices. "They get a mild stimulation and a lot of oral anesthesia, which may last an hour or so before it fades out."

On the other hand, Indians living in the Amazon region use a much stronger preparation. The coca leaves are toasted crisp, pulverized, and mixed with ashes from other tree leaves, as coca has to have an alkali added to make it work. The powder is then worked to a lump in the mouth, and sucked.

Dr Weil has lived in Amazon communities where every hut had a prepared can of coca powder which was renewed frequently. Anyone could dip in.

"But I never saw it used except on very special occasions, usually as a stimulant to physical work before going out to chop down trees, or as part of a ritualized party.

"I did not see it used by children, I did not see it used by adolescents, and generally it was not used by women."

Coca leaves are rich in vitamins and minerals, often in concentrations higher than certain food crops available to the Indians.

Why and how coca works is a research blank.

Dr Weil believes "there is no one single important compound with coca. I think it is the interaction of all the substances.

"People have suggested that ecgomine, a breakdown product of cocaine, is the primary pharmacological agent. When coca leaves are chewed with alkali, most of the ecgomine is converted to other substances, which are less reinforcing and less stimulating than cocaine.

"This suggests, for example, that to inject laboratory animals with cocaine might have absolutely nothing to do pharmacologically with what happens when a human being chews coca."

Coca has a low abuse potential "because you have to do a good bit of work to get the effect. Chewing a mouthful of leaves and sucking is not as easy as snuffing a powder or swallowing a pill," Dr Weil adds.

Cocaine users get a product that is some 60% pure. A wad of coca leaves in the mouth contains about 0.5% cocaine, and this is modified by the action of other substances.

Dr Weil has found in his travels "most people not only don't attribute bad effects to coca, but say that it has very distinct good effects, particularly on digestion, assimilation of food, and on the mouth."

During the past year Dr Weil was asked to brief agents from the Drug Enforcement Administration at the American Embassy in Lima. The agents were concerned because the coca leaf growers did not think what they were doing was wrong.

The DEA agents said they thought this was discouraging "because even the farmers in Turkey admit opium is bad for them."

"I told them they would not find that with the people who grow coca," says Dr Weil.

Dr Weil has taken the opportunity to use coca on a number of non-Indian patients and from this has developed a fervor to use the leaves medically.

When used for patients with gastro-intestinal upsets "it just makes spasms and pain go away." He believes the effect is more than that of a topical anesthesia.

"But even if that is so, it is important because many gastro-intestinal problems are a vicious cycle: discomfort causes a feedback to the brain and that, in turn, causes a worsening dysfunction of the musculature.

> *'I'd like to see coca leaves as a therapeutic drug and, after that, as a recreational drug.'*

Chewing coca leaves cures motion sickness.

Dr Weil would like to use coca as a substitute for coffee for people with gastro-intestinal problems, and ulcers. They would get a great deal of oral gratification through taste, and the topical anesthesia effect.

Another important coca use could be with the obese. "It is easy to motivate people to be physically active when chewing coca.

"I have told overweight people to chew the leaves and then go for a run."

There may be a use for coca as a mild stimulant and as an anti-depressant. "However, I think the key factor here would be a careful selection of patients," Dr Weil cautions.

His interest in coca leaves has led Dr Weil into studying cocaine. He has been involved in several court cases, including a recent one in Roxbury, Mass. where a judge dismissed charges against a man who had $20 worth of cocaine in his possession. (**The Journal**, January).

Dr Weil has found: "If people have a lot of cocaine available they seem to have difficulty in regulating their intake. I have never seen that with coca.

"I have been around Americans who live in South America and who had large amounts of cocaine available. They would use cocaine all of the time and to the exclusion of other things. They would just sit around unfurnished rooms and snort cocaine.

"I have a feeling that with unrestricted access, a pattern might emerge. It could be similar to what happened with speed: there would be a spree of use and then at some point the person stops taking it because he needs to sleep and make up for the energy loss.

"Maybe people can work out some sort of relationship. Not everybody has difficulty with cocaine. But I have seen people have more trouble with cocaine than with any other drug.

"One expression of this is any situation where cocaine is available: it always gets used up. That is not true with other drugs, and I have never seen that with coca.

American hippies are the only people he has seen trying to smoke coca leaves.

Dr Weil points out that coca received an undeserved reputation in the 18th century when leaf extracts were mixed with wine. The route of administration had been changed, and that is crucial.

Chewing the leaves is vital. The drug works, as it should, "through the mucous membrances and partly through the stomach, but only after holding the leaves in the mouth."

Dr Weil says because he has seen so much coca used at first hand, and realizes how valuable it is as a therapeutic drug, "I am very upset at the failure to distinguish between coca and cocaine in this country by both government and by scientists.

"There is a lack of awareness among scientists to differentiate between the plant drug and the isolated derivatives. That is hard to fight against."

The current concern in the US about cocaine has an economic impact in Bolivia and Peru, where coca cultivation, distribution, and sales are regulated by government monopoly.

In Peru, the national coca office taxes the crop, licenses growers, and distributes the crop. When he was last there, Dr Weil found coca selling for from $3 to $5 a kilo.

Peru grows the most coca and exports the least, legally. It is estimated that 60% of the crop is turned into illegal cocaine.

A great deal of pressure has been put on both Peru and Bolivia to stop coca growing.

"But from what I have seen there, it would not only be impossible, but it would be very unwise. Thousands of peasants depend on growing coca and it is the only thing that will grow for many of them.

"There has been an enormous resentment generated because the United States has come in and tried to advise Peruvian officials on how to substitute other crops for coca. It has caused a great deal of disruption of the economy."

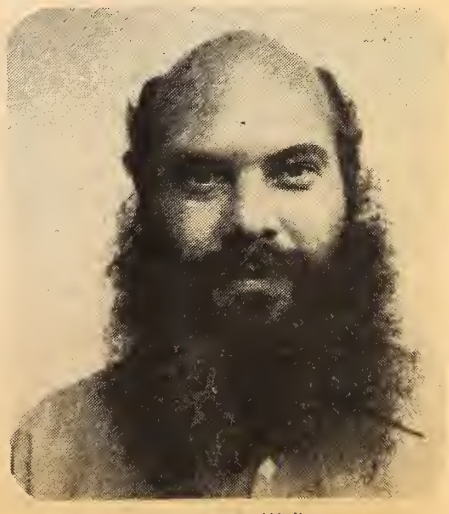
Peru signed, in 1964, a 25-year agreement which would have led to the final elimination of coca growing. "In fact, coca production since then has doubled and goes up about 10% a year," according to Dr Weil.

Dr Weil is passionate in his advocacy of coca.

"I think the abuse potential is minimal, and compared to almost any other drug that I know, I think the potentialities of coca are very high.

"I would like to see coca leaves available to physicians as a therapeutic drug, and I am working to achieve that. I would like also to see it available after that as a recreational drug.

"It seems to me a shame we have denied ourselves the use of this substance."



Andrew Weil

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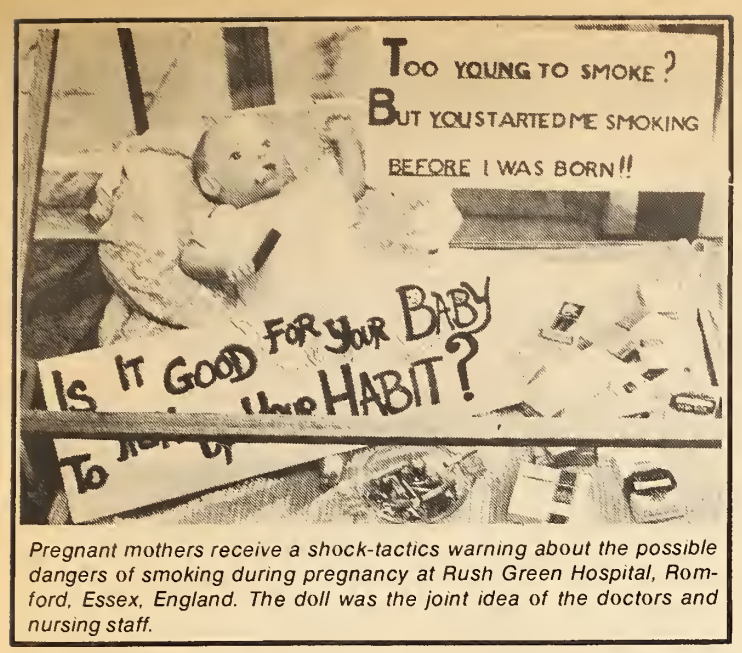

Pregnant mothers receive a shock-tactics warning about the possible dangers of smoking during pregnancy at Rush Green Hospital, Romford, Essex, England. The doll was the joint idea of the doctors and nursing staff.

Lalonde and Basford back revival

Pot bill not buried yet

By Bryne Carruthers

OTTAWA — Two federal cabinet ministers, Ron Basford of Justice, and Marc Lalonde of Health and Welfare, are trying to revive the federal legislation to ease penalties for cannabis possession.

The Journal has learned that the ministers are planning to ask cabinet approval for a further liberalization of the legislation on marijuana and hashish.

Two important additions are being considered: the elimination of the automatic taking of fingerprints by police of persons charged with simple possession of cannabis; the elimination of an automatic criminal record, again in cases of simple possession.

In addition, consideration is being given to lowering even more the fine that would be imposed for first offence, simple possession.

The current fine being imposed by courts averages about $200.

The liberalization in the cannabis bill, as proposed by Mr Basford and Mr Lalonde, does not extend to more serious cannabis crimes like trafficking and importing.

The bill, approved by the Senate but still requiring Commons approval, already proposes to eliminate jail terms for simple possession crimes, and instead to levy fines.

Jail terms could be imposed where a convicted person fails to pay a fine. This would be retained under the proposed liberalization because government officials believe that without the threat of

(See — Pardon — page 7)

The Journal

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Mother's daily beer boosts risk of still birth

By Lynn Payer

PARIS — Women drinking relatively moderate amounts of beer daily at the beginning of pregnancy had a significant increase in the number of stillbirths and small-for-date infants, according to a study here of risk factors in pregnancy.

The study was sponsored by the Institut National de la Santé et de la Récherche Médicale (INSERM) here.

Monique Kaminski, of the Unité de Récherches Statistique of INSERM in Villejuif, said that in the prospective study of more than 9,000 pregnancies, women at the beginning of pregnancy were questioned, among other things, about their consumption of wine, beer, and cider. A daily consumption equivalent in alcohol content to 40 centiliters of 11 degree wine was arbitrarily chosen as a dividing line, with the 509 women, admittedly drinking more than this daily, considered moderate to heavy drinkers.

The rate of subsequent stillbirths in this group was 26 per 1000, compared to 10 per 1000 in the group with a daily consumption less than 40 cl of wine. There were also relatively more small-for-date infants, and the mean birthweight and the mean placental weight were smaller in the drinking group.

But when the drinking group was further analyzed as to the types of beverage drunk, the increased risk appeared to be almost entirely due to beer, with women who drank exclusively beer and cider having 38 per 1,000 stillbirths, even though they consumed less alcohol than the wine-drinkers.

For women who drank only wine, there was no difference with the light-drinking group, except a slight tendency, not significant, to smaller infants and lower placental weights. In the group drinking both wine and beer, the results were intermediate, with a significant excess of stillbirths and small-for-date births.

Ms Kaminski and her co-authors, Dr C. Rumeau-Rouquette and Professor D. Schwartz, found no difference in the incidence of birth defects, neonatal deaths, prematurity, or in the mean gestational age related to alcohol consumption. Nor was there any apparent influence on the sex, or the incidence of twinning.

Since the break-off point of the equivalent of 40 cl. of wine had been arbitrarily chosen, analysis was also made of consumptions below and above this.

The authors found no difference in the outcome of pregnancies where the mother drank between 20 and 40 cl. or not at all. The threshold of increased risk seemed to be somewhere between 40 and 60 cl. and increased above this threshold with increased consumption.

Because women may have underestimated their consumption, this threshold may in reality be higher, said the authors.

However, they pointed out similar low thresholds have been found in women for other risks,

(See — Low — page 7)

NIDA and NIAAA may be merged

WASHINGTON — Several influential US Senators are considering the introduction of legislation that would merge the National Institute on Alcohol Abuse and Alcoholism and the National Institute of Drug Abuse into one agency.

When, and if, the bill is introduced depends in part on reaction from President Jimmy Carter's administration and possible plans now being considered to cut down on the number of federal agencies. (See page 9).

Some of the backers of the proposals, which have Democrat and Republican support, have asked the Council of State and Territorial Alcoholism Authorities and the National Association of State Drug Abuse program Coordinators to survey members on the idea.

The two organizations devised a joint questionnaire which asks state officials the status of local programming with respect to combined services, and whether they think a merger will facilitate an orderly flow of federal assistance to local service delivery programs.

State officials are also being asked to give their opinion on a merger.

Few see cocaine's abuse potential

By Harvey McConnell

WASHINGTON — Abuse potential of cocaine if it becomes less costly and more available is not receiving serious enough consideration.

Donald Wesson and David Smith, of the San Francisco Polydrug Project, say in a report: "The difference between current *abuse* versus *abuse potential* is a concept not well understood by many laboratory scientists, by drug experts who do not see cocaine abuse in their treatment programs, and by the general public."

Their investigations into cocaine abuse have been submitted to the National Institute of Drug Abuse as part of a NIDA study into cocaine and health, which will be published later in the year.

Commenting on the report, Dr Smith told **The Journal** that because of the present high cost, around $1,500 an ounce, cocaine is, for the moment, rarely abused.

"But when the individual has access to large quantities, then it can be abused. The people I have actually come into contact with and treated have been rockstars, dealers, and heirs."

Dr Smith pointed out that these patients do not come to the Haight-Ashbury Free Medical Clinic, of which he is medical director, but attend privately. Because they are wealthy, they do not have the social and economic pressures of many drug abusers.

"The cocaine abusers I have seen do not have a serious under-

(See — Cocaine — page 7)

NORML opens Vancouver office

By Tim Padmore

VANCOUVER — A new national organization to lobby for the decriminalization of marijuana use planned to open its first office here in February.

The group has taken the name NORML (National Organization for the Reform of Marijuana Laws), and will be affiliated with the US organization of the same name.

Seven American states have listed penalties for pot possession in response to lobbying by NORML and others, and similar reform is being considered in 30 other states.

The group is being incorporated in Canada as a federal society. Directors will be John Conroy of Abbotsford BC, Roger Jacko and Edward Seifred of Vancouver, and Clayton Ruby of Toronto, all lawyers.

Mr Seifred said in an interview with **The Journal** that NORML Canada's policy parallelling that of its US partner, will be to "support the removal of all criminal and civil penalties for the private possession of marijuana for personal use. The right of possession should include other acts incident to such possession including cultivation and transportation for personal use and casual non-profit transfers of small amounts of marijuana."

Plans at press time were to open a Vancouver storefront office for distribution of literature and signing up of members by the end of February, and to open a similar Toronto office within a few months.

• Abuse prevention programs in schools across the US have shown 'fantastic' results measured by a decrease in abuse of alcohol and other drugs, a decrease in drop-outs, and decreases in vandalism and racial conflict. Dr Helen Nowlis is responsible for the program that really works. See page 4.

• The music has ended but the memory and a few members of the Canadian temperance movement linger on. Perhaps surprisingly, most areas of Canada have a group committed to the philosophy of abstinence from alcohol. See The Back Page.

Regular Features

US borrows 'Lifestyle' to promote road safety

By Harvey McConnell

WASHINGTON — Canada's Lifestyle program and animated cartoons are being borrowed here as American highway safety experts search for ways to cut the death toll on roads, especially accidents involving alcohol.

The need is urgent, according to Dwight Fee, special assistant to the director of driver and pedestrian programs for the US department of transport.

"We are reaching a point of diminishing returns in terms of programs: what is the government going to do for you, or to you?

"Nobody cares about that any more. What can I do for myself is the question."

He was galvanzied when he first saw a copy of the Canadian program (The Journal, July, 1976). "I immediately wrote and got 100 copies and sent it to all our people in highway safety. It is the first thing I have seen that points out the importance of accident prevention in health care.

"It is so clearly written and so well organized that, one, you read it. It is a challenge you can't walk away from."

The DOT here has also received permission to use animated cartoons about wearing safety belts.

Mr Fee said: "What we are trying to do is to help the consumer see three things: if he is cautious about his use of alcohol before driving; if he wears his safety belt, and here again we are watching Canada very closely; and if he stays within posted speed limits, he can forget about highway safety.

"I think we would reduce the toll to the irreducible minimum."

Using the Lifestyle issue "gets us out of the old trap we used to be in where people regarded highway safety and drinking as a game," he added.

The emphasis has been on the legal blood alcohol concentration of 0.10% "which is not a safe limit at all, just a legal limit."

The focus must be on voluntary action to prevent the driver from reaching a dangerous BAC level, and if he does, to stop him driving voluntarily.

Lowering the legal BAC limit would achieve nothing. Mr Fee pointed out: "We don't have the police now to enforce the present legal limit. The average level of arrests is about 2.2% it is estimated.

"You can't really scapegoat this highway safety problem any more. You can't say it is the drunk driver, it is the other guy, because it isn't the other guy exclusively. It requires individual decisions as well."

Trying to reach the 19-to-24-year-old group, who are already over represented statistically in traffic accidents, is especially difficult. Research has shown alcohol attacks judgement before skill, and then attacks the most recently learned skill, Mr Fee pointed out.

"So, you have got a fatal combination any time alcohol is involved with young drivers. Yet we have got people around who calculate how much they can drink over a period of time and still be within the legal limit.

"The whole emphasis is on the legal limit and the kids use this to learn how to avoid legal arrest."

Many members of this age group are out of school, and the Lifestyle argument does not yet fit into their scheme of values. The best way, so far, to reach them is through spots on radio and at drive-in movies.

Concerted action can be extremely effective such as the Alcohol Safety Action Project, which is now winding down. Some $80 million has been spent since the program started in 1970 in 35 areas around the US.

Under the program, when a drunk driver was arrested, an investigation was made to try and diagnose the reasons for his drinking problem. This was presented to the court and appropriate action taken.

The drunk driver was usually given the choice of having his licence revoked or of going into a treatment program.

Mr Fee said ASAP has demonstrated: "If the police and health people cooperate and converge on the court, then the court is bound to cooperate. It has also been a marvelous case finding system for people with alcohol problems."

When the program was launched, only four states did not demand automatic revocation of a driving licence on conviction of drunken driving. The result was that most offenders asked for a jury trial, were acquitted by the sympathetic members, and for this reason police stopped arresting drunken drivers.

When the courts had the option, under the program, of suspension or treatment, it proved very effective.

"Once the police understood it as an enlightened process — the driver did not get the book thrown at him, but he was not getting away with it — it worked," Mr Fee continued.

A good example *is Fairfax* County, Virginia, across the river from Washington. The year before ASAP started, police arrested three drunken drivers. In the first year of the program they arrested 1,500.

Now, more than 12 states have modified their legislation and allowed court discretion.

Mr Fee said ASAP is the perfect example of a demonstration project working.

Former addicts may be protected

Methadone can depress respiration

By David Milne

SAN FRANCISCO — Methadone can severely depress the respiration, but former addicts develop a tolerance that tends to protect them, according to a report given here to the American Society for Anesthesiologists.

In non-addicts, however, the respiratory depression is significant and long-lasting.

The respiratory depression produced by methadone is about one-half that produced by morphine, said Thomas H. Cromwell, assistant professor of anesthesiology at the University of California Medical Center, San Francisco.

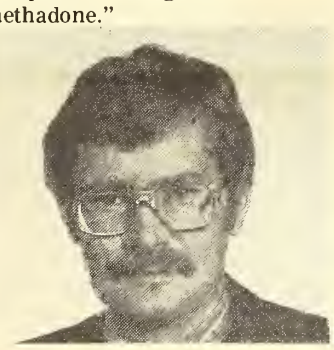
The immediate cause of death in narcotic overdose is often severe respiratory depression, he explained.

"Methadone, being a narcotic, would be expected to produce significant respiratory depression, although very little has been known about its respiratory effects," said Dr Cromwell.

"Since many former addicts are now receiving large doses of methadone, they may experience potentially dangerous respiratory depression unless they become tolerant to the depressant effects of the drug.

"Previous research indicates that respiratory tolerance to methadone does not develop.

"This could mean former narcotics addicts on methadone could be at risk, particularly if their methadone dose was increased, if they developed a respiratory disease, or if they continued to use heroin or morphine along with their methadone."



Thomas Cromwell

Dr Cromwell reported on a study in which he assessed the respiratory effects of methadone.

Different doses of the drug were administered to 10 volunteers with no history of drug abuse and to another 10 volunteers who were former narcotics addicts and were now on methadone maintenance.

A comparison was made of respiratory tests before and after administration of methadone in all subjects.

"Results of the study indicate that the respiratory depressant effects of methadone in non-addicts are significant and long-lasting," said Dr Cromwell.

Marilyn Harper

Of even greater concern is the finding that respiratory depression may last for 24 hours or more following a single dose of methadone in some individuals.

These results indicate that the illicit use of methadone by non-addicts could produce respiratory depression with severe consequences, even death.

"Fortunately, in contrast to previous research, the results of this study indicate that former addicts now on methadone maintenance do develop tolerance to the respiratory effects of the drug.

"Accordingly, their methadone use does not subject them to undue risk of respiratory disease in the event they develop a pulmonary disease or increase methadone dosage," he said.

Associated in the study were Dr Marilyn H. Harper, assistant clinical professor of anesthesiology and Rita Cahill, RN, both of the department of anesthesia, University of California Medical Center, San Francisco.

Something's askew with spaced-out authors

By Wayne Howell

THE ARMIES of the Night, Norman Mailer's Pulitzer Prize winning chronicle of the October 1967 march on the pentagon, and *Fear and Loathing on the Campaign Trail*, Hunter S. Thompson's critically acclaimed account of the 1972 presidential campaign are interesting books; interesting in that both achieved their initial fame because of the belief that the authors were in an altered state of consciousness during the time the books were written. This belief was cultivated by the authors themselves.

Here is Mailer, for instance, presenting his credentials as a political journalist in the prologue to *Armies of the Night*: "Mailer had a complex mind of sorts . . . he had given his own head the texture of a fine Swiss cheese . . . he had made all sorts of erosions in his intellectual firmament by consuming modestly promiscuous amounts of whiskey, marijuana, seconal, and benzedrine. It had given him the illusion he was a genius . . . ". And here is Mailer again, proudly recording for posterity — in his own book — *Time*'s account of himself as a reporter-participant in the events of October 1967: "slurping liquor from a coffee mug . . . mumbling and spewing obscenities, he (Mailer) staggered about the stage".

Cut to Hunter S. Thompson, gathering together his essential writer's tools for *Fear and Loathing in Las Vegas*, the book that rocketed him to instant new-journalism stardom. Along with his portable typewriter, Thompson allegedly set out for Vegas with "two bags of grass, seventy-five pellets of mescaline, five sheets of high-powered blotter acid, a salt shaker half-full of cocaine and a whole galaxy of multicolored uppers, downers, screamers, laughers . . . also a quart of tequila, a quart of rum, a case of Budweiser, a pint of raw ether, and two dozen amyls".

Now it would appear to me that there is something seriously askew when gifted writers feel they have to appear to be in a perennial state of altered consciousness before they can deliver the goods, that is to say, provide us with unique and valuable insights.

And what we are seeing here is something quite different from what we have seen before; writers have traditionally been prone to excess, but with the exception of Coleridge none have attributed their art to their excess. Dylan Thomas, for instance, never claimed to have received the inspiration for "Fern Hill" under a table in a Greenwich village bistro; and Ernest Hemingway never claimed to have written *The Old Man and the Sea* on the way home from a night of quaffing daiquiris at Havana's Floridita bar.

Something, as I said before, appears to be seriously askew. And what I think is askew is the psychedelic-age reader's perception of the role drugs play in the creative process. In this regard the case of Hunter S. Thompson is very relevant, for there is a whole coterie of Thompson fans who firmly believe that their man has transformed himself into a sort of Tom Werewolf of the new journalism, a Budweiser-bloated, gin-soaked (he is reputed to employ a giant-sized medical syringe to inject a pint of gin into his stomach) drug-crazed not-quite-human-thing, and *because of this* he can provide valuable insights into the political process, insights that could be obtained in no other way.

This is somewhat disturbing, especially since the whole Mailer-Thompson 'shtick' is so patently phoney. Mailer, for instance, was a genius long before he ever smoked his first joint, and in all probability *The Armies of the Night* is a powerful and compelling work in spite of the fact that Mailer has taken drugs, not because of it. And, according to a source close to Hunter S. Thompson (R. S. Anson writing in *New Times* magazine), "when it comes time to write he (Thompson) puts away the drugs and concentrates on his craft, sculpting each sentence and paragraph with a care and precision that belies the stream-of-consciousness Gonzo style". In fact, Thompson learned to write the crazy scintillating prose that has made him a legend not from dipping into a tote-bag of uppers, downers, screamers, and laughers. He learned by studying the styles of Faulkner and Fitzgerald while he was still an unknown, working as a clerk for *Time*.

And it always has been thus. The poet Baudelaire was in some ways the Hunter Thompson of a century past — he boasted of his addiction to hashish, opium, and everything else that was available at the time, and he was given to scandalizing straight society with freakish Thompson-like stunts, such as leading a live lobster around on a leash. Commenting on this many years later, Ernest Hemingway had this to say: "I suspect that Baudelaire parked the lobster with the concierge down on the first floor, put the chloroform bottle corked on the washstand, and sweated and carved at the Fleurs du Mal alone with his ideas and his paper as all artists have worked before or since."

But the myths persist — and now, it appears, artists are actively involved in creating their own myths and perpetuating them; Mailer with his head full of cheese and Thompson with his gut full of God-knows what.

"He who makes a beast of himself", said Dr Samuel Johnson, "gets rid of the pain of being a man". What Dr Johnson would think about a society that feels a beast's-eye view of mankind is of more value than a clear-eyed view; and what Dr Johnson would think of a society in which its most gifted chroniclers feel they have to appear to be beasts, is anybody's guess.

(Wayne Howell is an Ottawa physician and freelance writer).

Gambling — an 'epidemic' in the US, according to sociologist Tomas Martinez.

Gambling addicts are being ignored

BOULDER, Colorado — A University of Colorado sociologist claims that a "gambling epidemic" is raging throughout the United States, involving up to 10 million compulsive gamblers, "but it could take maybe 10 years until government policy recognizes it."

Compulsive gamblers wager for the same reasons alcoholics drink or drug addicts use heroin — to get high, says Tomas Martinez, who has spent 10 years studying gambling in America.

Mr Martinez says gamblers often see themselves "as having prestige, performing daring and forceful actions."

He said one compulsive gambler, for instance, would imagine himself as an international gambler with international money backing him.

He said a person could become a compulsive gambler in about six months but the process often takes longer.

Compulsive gamblers come from all social classes and find forms of gambling suited to their preferences.

"That's the beauty, or danger, of gambling," he said. "If you're a social person you can play cards and face off with people. If you're a loner, you can bet on horses."

Mr Martinez said compulsive gambling, like an addiction, can lead its victims to such consequences as loss of job, jail, family breakup, and attempted suicide.

He said the cure rate for chapters of Gamblers Anonymous is only about 10%, and the cure is not necessarily permanent.

Smoking-related deaths increase in Canada

By John Shaughnessy

OTTAWA — Annual death rates for one smoking-related disease decreased in Canada between 1961 and 1973, but for two others the death rates increased.

Statistics released recently by the federal Department of National Health and Welfare indicate the annual rate of death from ischemic heart disease has substantially decreased since the middle 1960s, regardless of sex. However, the total number of deaths from chronic bronchitis and emphysema combined increased 193%, from 1,006 in 1961 to 2,943 in 1973.

The department, in its report, offers no explanation for the changes, but says that an explanatory analysis of these trends is now being attempted.

With respect to ischemic heart disease, the report suggests a partial explanation for the decline in the annual death rate may lie in the progress made by medical technology in diagnosing and treating this illness. Overall, the department found that in 1973, 50,482 deaths (30,689 male and 19,793 female) were attributed to ischemic heart disease (excluding angina pectoris), an increase of 25.7% over 1961.

However, age standardized rates for this period indicated a steady decline in ischemic heart disease mortality. Among males, the mortality rate decreased from 280.8 per 100,000 in 1961 to 268.2 per 100,000 in 1973, a decrease of 4.5%. In the female population there was a decrease of 11.2% between 1961 and 1973 from 158.2 to 140.5 deaths per 100,000. (From 1950 to 1961 the mortality rate for ischemic heart disease increased 39.4% for males and 39.8% for females.)

Decreases in heart disease mortality were found in all age groups over 40 years of age (with the exception of those 85 years of age and older) between 1961 and 1973 with the greatest decreases occurring in males 45 to 54 years old. Similarly, a decline in mortality was evident among females over 45 years of age during this period, particularly in the age groups 50 to 54 and 65 to 69 years.

However, the statistics revealed the greatest percentage increase in ischemic heart disease mortality occurred among women 40 to 44 years of age — an increase of 39%.

With respect to deaths from chronic bronchitis and emphysema, the department comments the mortality trends for these causes of death are in many ways similar to the trends reported for lung cancer mortality.

In 1973, 1,477 deaths (1,217 male and 260 female) were attributed to chronic bronchitis, an increase of 147.4% over 1961. The data indicate the male mortality rate increased from 5.4 per 100,000 in 1961 to 12.2 in 1971, a percentage increase of 125.9. However, a decline in the mortality rate was noted between 1971 and 1973 "which may indicate a levelling off or reversal in chronic bronchitis occurred in male chronic bronchitis mortality." The female mortality rate increased 109.1%, from 1.1 per 100,000 in 1961 to 2.3 in 1972, but as in the male population, a recent decrease in the female rate is apparent.

The chance of dying from chronic bronchitis increases rapidly among males over 35 years of age, according to the report. In 1973, for example, the male mortality rate rose from 0.2 per 100,000 for those aged 35-39 to 304.9 per 100,000 for those over 85 years of age.

Between 1961 and 1973 increases in chronic bronchitis mortality occurred in all age groups over 35. These changes, however, were found to be somewhat irregular, with rates fluctuating from year to year. Similarly, mortality rates for females over 35 increased rather unsteadily during this period.

Decreases in mortality due to chronic bronchitis occurred in both the male and female populations in recent years, particularly among males aged 55 to 74 years and females over the age of 70.

Emphysema data for 1961-1973 indicated the proportion of total deaths due to this respiratory disease gradually increased for both the male and female populations, 35 years of age and over. Reflecting this fact, the percentage of total deaths due to emphysema increased for males from 0.4% in 1961 to 1.4% in 1972. For females, the percentage rose from 0.1% in 1961 to 0.4% in 1971. In 1973 the percentages dropped to 1.3% for males and 0.3% for females.

More specifically, the male mortality rate increased from 3.9 per 100,000 in 1961 to 11.0 in 1973, while the female rate during this period rose from 0.5 to 1.8.

In contrast to the period 1950 to 1961, the overall percentage increase in emphysema mortality was larger for females than males. For males, the percentage increases for 1950-61 and 1961-73 were 255% and 180% respectively. For females the percentage increases for the same periods were 150% and 238% respectively. The percentage increases between 1961 and 1973 were most pronounced for females 55 to 69 years of age.

It can be life threatening

Lot says salt is addictive substance

By Jean McCann

SAN ANTONIO — Millions of people are daily ingesting the tiny white grains of an addictive substance which is killing them. And they don't even know it.

The addictive substance is salt. How does it kill? By fostering hypertension in genetically-susceptible individuals.

But isn't "addictive" too strong a term for a substance so commonly used and even referred to in the Bible as a favorable food substance?

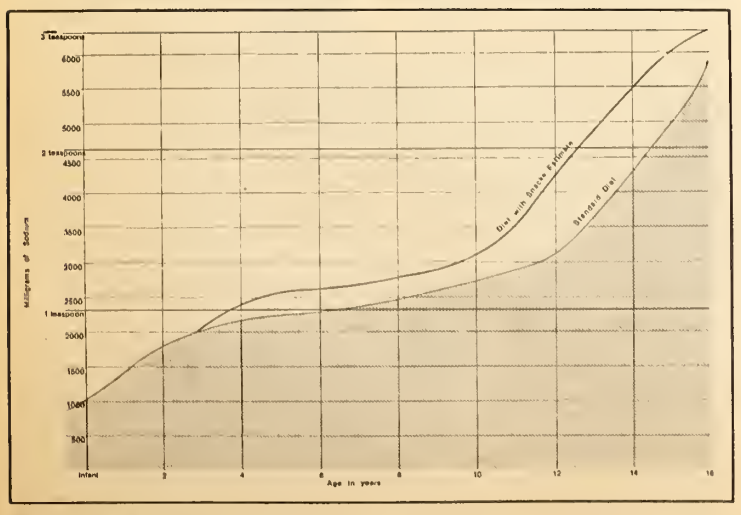
Not according to a researcher here at a seminar sponsored by the American Heart Association, and who is named appropriately — or inappropriately — Lot. (It was Lot's wife who, in the Bible, looked back and was turned into a pillar of salt).

This modern Lot, Lot B. Page, who admits his wife thinks he should have taken up another interest, is quite firm on this matter of salt and addiction.

Asked if salt should be regarded as an addictive substance, Dr Page answered: "I think that's a reasonable term, yes.

"Once an individual is exposed to salty food, the appetite is set in such a way that the individual craves salt, and will continue to crave it, the rest of his life.

"Also, evidence in animals shows that the younger the animal is when exposed to salt, the greater its susceptiblity to high blood pressure in the future.



While studies show children and adults need only one-tenth of a teaspoon of salt per day, average intake of sodium in the US ranges from six to 40 times as much as the body needs, according to Lot B. Page, chief of medicine at Newton-Wellesley Hospitals, Mass.

"It is also clear from animal experiments that chronic salt loading has a delayed effect. It does not cause high blood pressure immediately, but sets in motion — in the 15% to 20% of the population which is susceptible — an upward trend which eventually becomes irreversible and is no longer corrected by reducing salt intake."

Dr Page, who is chief of medicine at Newton-Wellesley Hospital in Newton Lower Falls, Mass, and who has studied the salt habits of many societies, said the current North American teen preference for salty snack foods is especially reprehensible.

"Metabolic studies have shown that both children and adults require no more than 200 mg of sodium a day, corresponding to one-tenth of a teaspoon of table salt. Yet, detailed data on habitual intake in different segments of the US population ranges from six to 40 times as much as the body needs."

Dr Page urged parents of infants to start them off on recently developed no-salt baby foods.

Older children and adults should also drastically reduce salt intake, although it may be too late for people aged 40 or more who have already developed irreversible hypertension, said Dr Page.

He also believes consumers must pressure food processors to cut out salt in their foods.

"If you look for low-salt foods in the market now, you'll usually find they're expensive, unpalatable, and in a dusty corner of the shelf called foods for invalids. But the food industry, if properly motivated, could provide excellent substitutes for the salty snack foods we now use."

Dr Page also noted that hypertension runs in families, and that parents should be particularly careful about salt for their children if they themselves have high blood pressure.

To find out whether a child does have upward-tracking blood pressure, he said, the child should be checked by the doctor. This can be done as early as age three.

Speakers here noted that hypertension may be unknown to the person who has it, so blood pressure should be checked at least yearly. Drug therapy is available which can save the lives of those who have it, to keep them from dying of heart disease or strokes.

Total ban possible

Smoking on airplanes

WASHINGTON — Cigarette smoking may soon be on the way out on United States commercial airlines if the public response to a proposed ban is anything to go by.

It will take months for the Civil Aeronautics Board to sort out the more than 25,000 responses it got when it decided to extend (The Journal, January) the time limit on replies.

The CAB considered originally a ban on cigars and pipes, but an extension was asked by Action on Smoking and Health and the question of a total ban was raised.

If the CAB decides that a total ban is what is necessary then it will grant more time for public comment. The CAB does not require that any smoking be allowed on planes and three commercial airlines have a complete ban on smoking.

Dr Helen Nowlis: 'Fantastic things'

The abuse program that works for young people

By Harvey McConnell

WASHINGTON — Prevention programs, especially those for young people, often look good on paper and that proves to be about all. But if one works, as Helen Nowlis has found, results speak for themselves.

Now in her sixth year as director of drug education for the US Department of Health, Education and Welfare's Office of Education, she can say: "there have been some fantastic things done.

"Whole communities have been turned upside down and made much more responsive to youth and the needs of youth.

'Community after community reported a decrease in destructive use of alcohol and drugs.'

"We don't have a nice, neat scientific evaluation with control groups. Besides, I don't think you can do it.

"But community after community has reported a decrease in destructive use of alcohol and drugs, a decrease in dropouts, a decrease in vandalism and a decrease in racial conflict."

Dr Nowlis, who has often worked in Canada, has received recognition of her efforts in quite diverse manners.

Last fall she received the 1976 recognition award of the Alcohol and Drug Problem Association of North America.

Now the Law Enforcement Assistance Administration, which wants to mount a program to combat violence and crime in big city schools, after a national study "has asked us to use our system and our strategy to attack this problem."

Which, in good storybook fashion, is a long way from the quiet reaches of the University of Iowa, where in 1961 she and her husband, both psychologists, were teaching.

An old friend persuaded them to make what became the big leap from social developmental psychology "into psychopharmacology, in the days before it was called that." What started out "only as an excursion" changed her direction permanently.

At the request of the Navy they investigated the effects of many commonly used drugs: amphetamine, barbiturates, scopolamine, seconal among others.

They worked on the theory "you get only what you look for" and sitting around waiting was nonproductive. But four-man groups in social situations performing tasks might produce an answer.

"We were convinced at low dosage levels in some cases, and moderate dosage levels, you could play it like an organ." They were right.

An outside observer would think a group taking seconal had had too much to drink. If an individual was removed for testing he would go to sleep, but wakened and returned to the group he was off again.

Helen Nowlis

Dr Nowlis decided eventually that the variants were not worth pursuing down to the nth degree. She left to become associate dean, and eventually dean of students, at Rochester University, where her husband is still a professor.

In 1966, the US Food and Drug Administration, worried at the rising use of substances by college students, requested the National Association of Student Personnel Administrators to do an education program for college administrators. Dr Nowlis was asked to direct.

This led her into the whole area of drug use, as opposed to psychopharmacology. She made frequent visits to Canada and talked with David Archibald, executive vice-chairman of the Addiction Research Foundation of Ontario. They were two of the earliest consultants to the Le Dain Commission.

Dr Nowlis attended many conferences of the Student Personnel Association in Canada and participated in many summer training programs of the Addiction Research Foundation.

Four years later, in 1970, the Office of Education moved into the whole drug abuse area and asked Dr Nowlis to become chairman of a national advisory committee.

"Then an old friend of mine, Jerry Jaffe (then director of President Nixon's Special Action Office of Drug Abuse Prevention) encouraged me to come down to see if I couldn't do something that would make some difference."

She found the programs "going the traditional route. There were some 57 demonstration projects based on colleges, community or school districts. Another 55 projects were state education department based, very expensive, and the payoff varied widely."

Dr Nowlis surveyed the situation and then "sort of put together what I know about kids and development, communities and schools, and we started a program called Help Communities to Help Themselves.

"This has a lot to do with assumptions I make about how change occurs. That if it is going to be effective, and if it is going to be sustained, it has to occur from within a community, a school, a group."

'Training an individual and sending him back is throwing him to the lions.'

Five training centres were established around the US and interdisciplinary team training offered.

Dr Nowlis is firm on this point: "I don't believe in training individuals, I believe in training only teams. Training an individual and sending him back is throwing him to the lions.

"If you train a team of six to eight people who have various skills and interests and potential, then you have something that has an impact."

The program was dubbed "the mini-grant program" because the average grant was some $3,500 and could be used only to cover travel and per diem expenses for the two week training course. But the response was staggering.

"In the first year we had some 1,600 applications from 55 states and territories. We defined community very broadly. It could be an Indian reservation, army base, small town, suburb, a neighborhood in the city. The theory was you have to tackle small pieces with achievable goals."

Dr Nowlis said the training gives teams some basic concepts. In pharmacology, for example, "it is not that this drug does this or that, but all drug responses are dose related and there are wide individual differences in the way people respond to drugs."

There is adolescent development, "such as the tasks of adolescents and the areas in which they move and develop, or fail to move and develop."

Available human resources are assessed and a lot of work done to sharpen skills, such as communication, conflict resolution, and problem solving.

The team leaves with an action plan and goals. The training centre will respond with specific assistance in getting over humps in executing the plan.

In 1974 more emphasis was put on training school teams, involving members from administrators to nurse educators. The program paid $6,000 towards the salary of a coordinator for the team "because on the basis of our experience there needs to be somebody who has the free time and the energy," Dr Nowlis added.

Teachers are trained "so they are aware of the non-verbal communication that goes on all over the place. They get a diverse group molded into a team and not competing with each other."

Dr Nowlis is convinced that young people must be involved from the beginning so they have some ownership in the program, which must have a meaning and serve a function.

She points out: "For many of them drug use serves as a meaningful function. We don't like it and it is destructive, but for them it is a meaningful function because if they didn't like it, they wouldn't do it."

Accent is on positive outlets: identification, accomplishment, social relationships. Dr Nowlis said:

"What we have done is to define alcohol and drug abuse as merely one or two aspects of destructive behavior, and we are trying to deal with the causes of that destructive behavior.

"The community must be more aware of the fact that kids are going to learn and grow, and if they don't provide positive outlets, the kids may develop negative outlets.

"Schools need to be much more aware, not of what the teacher gets up in front of the class and says, but what they communicate to the kids via a grading system, rules and regulations, and outlets they give, so that kids have some room to grow.

"Growing up is a complicated practice, particularly in a society that can't decide, or doesn't know, what the adult roles are now."

'We have got some work ahead of us.'

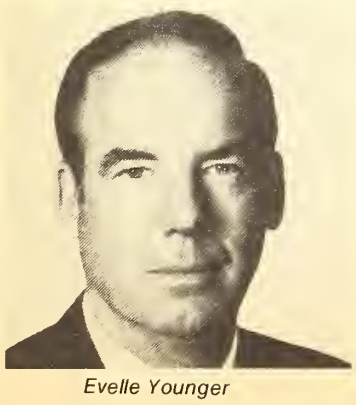
Parents must realize that children acquire more knowledge about drugs from parental example than anything else. "If the child has a headache or runny nose, they reach for the medicine chest, and you are teaching children that the way to deal with any problem is with a drug."

Dr Nowlis, who operates out of a professionally cluttered office in the depths of the new HEW building here, now has a major challenge and it may be the toughest of all: urban schools with 4,000 to 5,000 students in the big American cities.

"We have got some work ahead of us," she admits, but she is ready.

Drug abuse rampant in California

SACRAMENTO — Drug abuse in California runs rampant, far outstripping state and federal enforcement efforts, according to a recent report by state Attorney General Evelle Younger.



Evelle Younger

He estimates California heroin addicts shoot up 15 tons of heroin each year while narcotics agents seize less than 2% of the total.

There are one million drug abusers in California, defined by the State Health Department as those illegally using any drug except alcohol or tobacco.

And between 110,000 and 120,000 of them are addicted to heroin, says Mr Younger.

He estimates heroin addicts committed 525,000 robberies, burglaries, and thefts last year to support their habits.

Little is known of how many persons are using other drugs.

Mr Younger blames staff shortages for the arrest record not keeping pace with the burgeoning drug problem which has zoomed above the epidemic years of 1971-72.

State agents have focused efforts on apprehending major violators, he explained, but more manpower is needed.

The State Bureau of Investigation has 93 agents while the federal Drug Enforcement Administration has 314 agents in California.

The present report was the first step of an effort to assess the state's narcotic problem and resources needed to combat it.

California has about 25% of America's heroin addicts, says Deputy Attorney General Stephen Blankenship.

Accused's drinking rarely sways the court

By Manfred Jager

WINNIPEG — A University of Manitoba study linking alcohol abuse to crime has found that judges in Winnipeg tend neither to accept alcohol abuse as an excuse nor to impose harsher sentences simply because of a drinking problem.

The study, conducted last summer by law professor Michael Park and three law students, found that alcohol was a factor in 57% of about 5,000 crimes committed by 465 people.

Mr Park told **The Journal** that the finding is only an indication of the role of alcohol in crime because 90% of offenders are never caught, therefore it isn't known whether they drink.

A more conclusive finding of the study, however, was that judges in two downtown Winnipeg courtrooms of provincial judges court "are pretty well totally consistent in their attitude toward the offender and his involvement with liquor," Mr Park said.

The judges' responses to a survey administered by the researchers indicated they weren't going to punish a person over and above his crime because he was drunk or on drugs, but they weren't going to let him off lightly either because he was under the influence."

Although alcohol can be a mitigating factor in sentencing, judges look at the whole background, not just the presence of alcohol or drugs, Mr Park indicated.

A heavy drinker with a record of trying to overcome the problem through education or treatment was found to be less likely to be jailed than a person with no alcohol problem who committed a similar offence.

Eleven per cent of the offenders with no previous offences who had an alcohol problem were discharged, while 64% without liquor problems got discharges. Fines were issued to 76% of the drinkers and 22% of the non-drinkers.

Four per cent of the drinkers went to jail for first offences; none of the non-drinkers did.

Offenders with driving or liquor offence records received no discharges, but 66% of those who had drinking problems were fined, while 86% of those without alcohol problems were fined. Eleven per cent of the drinkers and 7% of the non-drinkers went to jail.

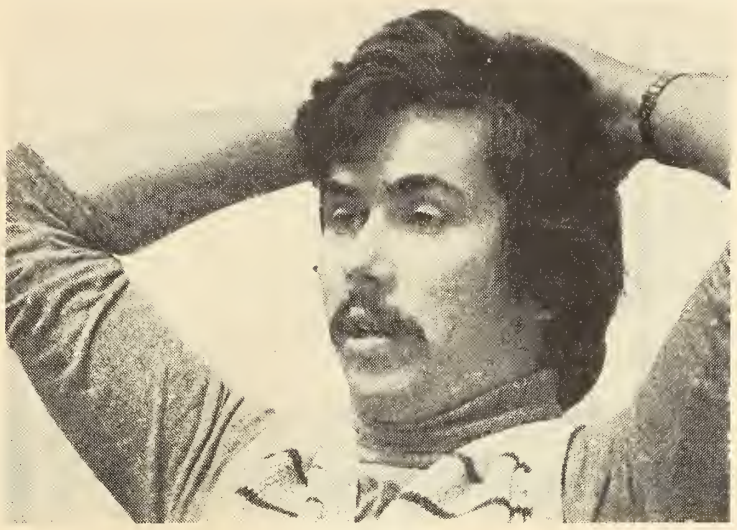
Four per cent of drinkers and of non-drinkers who had lengthy criminal records, got absolute discharges, but 56% of the drinkers in this group were fined, compared with 23% of the non-drinkers. Jail sentences were handed to 25% of the drinkers in this group and to 42% of the non-drinkers.

"What it means, as far as we're concerned, is that where you're dealing with petty criminals or people with no record, they are less likely to be sent to jail, less likely to be punished severely if they're not involved with alcohol at the time of their offence than a person who is involved with alcohol," Mr Park said.

The more hardened criminal, the person with the lengthy record, is given the benefit of the doubt, if there's evidence he's doing something about his drinking problem.

"What the judges seem to be saying is: 'If I send you to jail for 18 months, you're not going to get any treatment, it's not going to help your problem, it may only make it worse. On the other hand, if I give you a suspended sentence or put you on probation in the care of one of the agencies dealing with alcoholics, they will treat you. And because you have been attempting to deal with your problem, I'm not going to put the screws on you — I'm not going to throw away the key.'

"On the other hand, the judges tend to look at the guy without a drinking problem and say 'you don't even have the excuse of alcohol, and that's why I'm going to sentence you.' "



Michael Park.

Offences involved in the survey included thefts, assaults, robbery, incest, indecent assaults, alcohol and driving offences, dangerous driving, breaches of the liquor control act, soliciting, and possession of dangerous weapons.

Mr Park said he thinks consistency among judges whose courts were surveyed was almost perfect because "they are a very close-knit group. They're good friends off the bench as well as on the bench. Also, they meet at least half a dozen times a year for sentencing meetings, where they'll discuss given situations and the sentences they would require. If they don't agree they argue it out until they all do agree."

Mr Park said this makes for a system "which avoids the obvious flaw of being unequal. One of the quickest ways of bringing your system of justice into disrepute is to hand out unequal sentences for equal crimes. People lose all respect for this kind of judicial system. In Winnipeg they avoid this problem — and that's where 90% of our criminal justice is administered."

The research project was financed by a $7,300 grant from the Non-Medical Use of Drug Directorate in the federal health department, Mr Park said. He said that when it was completed, he sent copies of his report to the directorate with a request for an indication on how it was received. The request wasn't answered.

When Mr Park finally wrote Ottawa, saying he had about $200 of the grant left over and didn't know where to send the money, he was told to do with it whatever he wanted.

'One in six goes bananas'

Baboons smoke a lot like people

By Jean McCann

SAN ANTONIO — Eighteen baboons are smoking about two packs of cigarettes a day each at the Southwest Research Foundation in San Antonio, Texas.

Another 18 just puff away on filters.

The difference between these two groups of animals over the next four years or so (the study has already been going one year), is expected to shed considerable light on how smoking is involved in atherosclerosis, or hardening of the arteries.

A new phase of the study is also expected to illuminate behavioral aspects of smoking.

Clinical psychologist Walter Rogers, who is involved in planning the new phase already has a few clues that baboons, in some respects at least, are just like people.

"I trained the animals in groups of six, and this has given rise to a rule of thumb", he told **The Journal.**

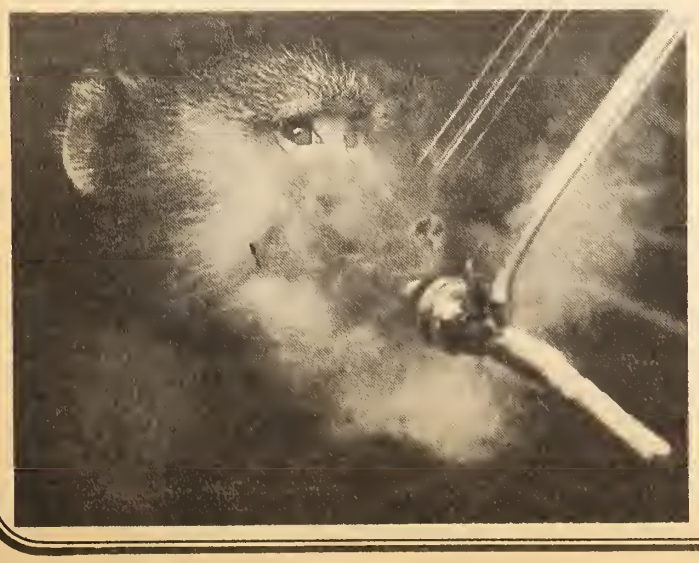
"One animal in six goes bananas. He'll start puffing away on the tube holding the cigarette, and he won't even drink the water he's being rewarded with for doing that. He'll just let it dribble on to the floor. These animals will smoke every 10 minutes like mad. If you want to infer they enjoy it, okay."

"One animal in six will be shocked by the first puff. He'll jump back, and wipe his mouth. And I've seen them sit there and not go near the tube that holds the cigarette for some 24 hours. But then, after a few days, they'll be earning all their water by puffing on the tube.

"Roughly four out of six animals don't make any special reaction. They'll just continue to puff on their tube as they did before we put the lighted cigarette in. So this has no apparent effect on their behavior whatsoever."

Dr Rogers said the first puff is the culmination of a long series of actions aimed at "teaching baboons to smoke." It's not easy, because the animals naturally lap or lick food and water, and do not normally suck, after the nursing period.

"What we have to do is to build up behavior little by little. When the animal exerts enough pressure by puffing on a cigarette, he's given a water reward.



"We start by teaching him to suck on a metal tube, and that's probably the hardest step in the whole thing. We put a water bottle in their cage, and they can get the bubble off the end by licking. Eventually they have to suck to get more.

"This is where I've got them; I modify the bottle so it's harder and harder to suck the water out. Then, eventually, they learn to suck on an open bottle with a tube going down it, and a cigarette holder attached above it. So now Mr Baboon knows all about sucking on this funny metal tube which will later be the cigarette holder."

When they suck hard enough, a sensoring device closes a pressure switch and establishes the minimum pressure requirements. Now, when the baboon sucks, instead of getting water directly, there is a clicking sound, lights flash, and he must move across his cage for his water reward.

Dr Rogers says baboons are intelligent animals, and after three or four attempts, they realize the only way they can now get water is by sucking on the metal tube, soon to become the cigarette holder, across the cage from the water.

Next, a filter, which has resistance to airflow just as a cigarette has, is inserted in the tube. In a day or two, the lighted cigarette is inserted, and from then on the baboon is a smoker, and earns all his water that way.

Regulation of the depth of inhalation, said Dr Rogers, is controlled by gradually increasing the pressure requirement needed to release the water. This ensures the animal is inhaling, not just taking mouth puffs.

The animals he's trained to date, are now averaging 44 cigarettes in a 12-hour day. But, whether they are addicted in the human sense is unclear, he said.

"We do know that if the attendants are 10 minutes late lighting the cigarettes, they'll all shake the bars in unison."

But do they want the smoking or the water reward? Dr Rogers said that if it's an addiction for the animals — as it seems to be especially for those who "go bananas" over it — then the nicotine component is probably what's most important.

"I believe nicotine has a large role in the regulation of smoking behavior because it affects neurons in the central nervous system, he said.

"Also, nicotine can cause a tremor from its effect on some of the motor neurons, and it's a pronounced vasoconstrictor."

Dr Rogers said that this summer, the behavior of the baboons will be examined before they start smoking, so it may be studied in relation to how they behave afterwards.

The behavior of the animals will be noted in the larger group, to see if personality, or dominance, perhaps, has some relationship to later smoking behavior.

"We do find now that some animals love it, some don't, and some are neutral; but we haven't correlated that. Maybe we'll find out that animals who are dominant in social groups take up smoking, for instance, but at this point we don't know."

Dr Rogers said he hopes eventually to study the effects of smoking in pregnant female baboons. "All the baboons in the large study so far are males, because we can't cope with too many variables simultaneously", he explained.

Methadone doesn't give sexual rush

SACRAMENTO — Methadone is not working as well as expected, says a University of California pharmacologist , mainly because it does not give addicts the same sexual rush as heroin does.

Frederick Meyer, professor of pharmacology at UCSF, made this assessment at a hearing by the state Senate Health Committee recently.

"People use heroin," said Dr Meyer, "because it feels good. This is the equivalent of an orgasm. It's a total body orgasm."

But methadone deprives the former heroin user of the sexual experience, often leaving him nervous, anxious, and often forcing him to turn to liquor and other drugs, he said.

Another pharmacology professor, Gary Henderson from the University of California at Davis, told the committee earlier that heroin addicts using methadone complain of constipation, sweating, and sexual disabilities.

"The tragedy of methadone," said Dr Meyer, "is that we cannot get people off methadone."

While he believes methadone is not entirely unsuccessful, Dr Meyer said more effort should be made to build detoxification centres and to separate heroin addicts from their old environment.

Primary care pivotal in WHO drug policy

Last month, Anne MacLennan examined the evolution of the United Nations and World Health Organization approaches to the opium producing tribespeople of the Golden Triangle. This month, John Shaughnessy reports on the WHO'S new policy and program in the prevention and treatment of drug dependence. It grew largely, out of experience in Thailand and may hold some valuable lessons for the West.

By John Shaughnessy

TORONTO — At first glance, a policy statement that simultaneously calls for more coordination and more decentralization seems confusing and self-defeating: the impression is particularly strong when the organization adopting this approach has a world wide sphere of activity.

Nonetheless, this seeming contradiction underlies the World Health Organization's new policy and program in the prevention and treatment of drug dependence. What's more, the underlying philosophy is based on hard realities encountered in this field.

In its pilot drug program in Northern Thailand (**The Journal**, February 1) the WHO discovered that opium production was a key element in the economic life of the nomadic hill farmers. Opium was also their major, if not only, medicine.

It quickly became apparent that drug abuse could not be treated in isolation from other health and economic problems of these people. Similarly, it was clear that treatment for the abusers in central, specialized institutions was inappropriate and impractical.

To halt production of opium and, at the same time, to treat and rehabilitate people in the communities with drug problems, workers soon became involved in crop substitution programs, in providing primary health care services, in helping people to learn basic hygiene, and even in building roads so the substitute crops could be taken to market.

'The global nature of the drug dependence problem requires great flexibility in the planning and development of appropriate responses.'

In simple terms, the attempts to deal with drug abuse in Thailand moved through a law enforcement phase, to an isolated drug therapy phase, and then to the current program of preventing and treating drug abuse in the context of primary health care and community development. In many ways, this evolution mirrors the changes in WHO's overall philosophy.

In the past, WHO often approached health problems on an individual program basis with separate expert committees tackling primary health care, family planning, drug abuse, vaccination programs etc. According to H. David Archibald, executive vice chairman of the Addiction Research Foundation of Ontario, and long-time advisor to the World Health Organization and the United Nations, the link between primary health care and specific problems such as drug abuse was rarely made in the bureaucratic systems of WHO.

Now, he says, the emphasis at WHO is on establishing effective links and setting up programs that take into account the inter-relation of primary health care, nutrition, the economics, and the culture of a country when attempting to alleviate a health problem such as drug abuse.

On an even broader scale, Mr Archibald says: "The global nature of the (drug dependence) problem, its negative impact on social, health, and economic development, particularly in developing countries, the rapid change of patterns of drug use and types of drugs used from country to country, and other known characteristics of the phenomenon, require great flexibility in the planning and development of appropriate responses.

"There are several important factors to consider in planning and implementing a program in the field of drug dependence. Services for treatment and rehabilitation should be integrated with other health, welfare, and economic development programs and the social and health damage from drug abuse should be assessed within the context of the overall health, social, and economic problems of the country.

'In drug dependence programs, the approach must always be to select and adapt to that particular society, experience gathered elsewhere.'

"The absence of basic health and social care services in rural agricultural societies, where opium and other natural psychoactive substances are produced, leads to the use of the substances as medication for the symptomatic relief of physical and psychic pain. In these areas, the approach to the problem should be the provision of primary health care services as part of a broad social, health, and economic plan for community development."

Going hand in hand with a broad based "drug program" such as this, is the need for a broad base of workers. The WHO suggests that all classes of health workers and other personnel such as teachers, social welfare workers, and police should have special training to enable them to apply their skills in programs on drug use and dependence.

Further, the WHO believes that treatment and rehabilitation should be viewed as a continuum. "The traditional separation of these functions in the management of drug dependent patients is no longer seen as relevant."

From an international point of view, there is now a considerable imbalance of resources, knowledge, and experience between developed countries and the developing world, and the WHO stresses the need for a well organized international system for the exchange of information and experience.

However, Mr Archibald cautions that models of treatment and prevention developed in North America and Europe are not necessarily transportable to Eastern, African, or South American Societies.

"In drug dependence programs, the approach must always be to select, and adapt to the particular society, experience gathered elsewhere."

Consistent with its broad based approach to treatment and rehabilitation, WHO is also taking steps to improve collaboration at the organizational and planning level.

Plans are underway for an effective coordination of drug dependence activities with other major WHO programs such as primary health care, country health programs and health education "in order to develop a much stronger foundation for collaboration with countries in the alleviation of drug dependence problems".

Within WHO, the mental health program has developed a system for the coordination of activities at headquarters, at the regional, and at the country level.

With respect to the United Nations' efforts, WHO points out that the fundamental objectives of all UN agencies involved in drug abuse control, prevention, and treatment is to ensure that maximum benefit is provided through adequate programs for people adversely affected by problems related to drugs throughout the world.

"It is therefore essential that effective collaboration and coordination of activities be maintained. There is need for more frequent meetings of senior representatives from all agencies involved in specific multi-agency projects. The purposes of such meetings should be to keep all participating agencies informed of progress; to act as an early warning system for problems and initiate early corrective action; to ensure that various elements of the program (for example health, law enforcement, and crop substitution) are coordinated at the country level; and to work closely with the appropriate national authorities.

Finally, WHO plans to develop collaborative relationships with a number of well developed "centres of excellence" and appropriate non-governmental organizations in the field of alcohol and drug dependence. The objective here is to concentrate on information transfer whereby the knowledge and experience available in collaborating centres can be better utilized by WHO and adapted by developing countries.

Implicit in the WHO policy on the prevention and treatment of drug dependence, is a rejection of the single problem approach to health care.

This is not surprising, says Mr Archibald, since with the exception of smallpox, and to a lesser extent malaria, health problems that have been attacked in isolation have not been seriously diminished.

And it is this aspect of the WHO experience which he feels can be of value to health workers and planners in the West.

"One particular area in North America where health and social programs have attacked problems in isolation and have generally been fruitless, is in the services provided for our native peoples.

"We've run programs for the Indians dealing with housing, with alcohol abuse, with education, with any number of social ills, but we've always attacked the problems one at a time or side by side. We've wasted a lot of money; in our planning we've ignored the interrelation of the problems, and in the programs we've ignored the potential contribution of the native people and the resources in the communities where the problems exist."

On a more philosophic note, Mr Archibald suggests the health systems in North America were founded on two basic assumptions. The first was that health problems could best be solved by science and technology and the second was that North America had virtually unlimited resources.

"Consequently the delivery systems revolved around hospitals and other institutions with little attention being given to existing community resources or to the use of health care people who are not specialists."

'To plan effectively and run any comprehensive health program, a sharing of information and a sharing of work is vital.'

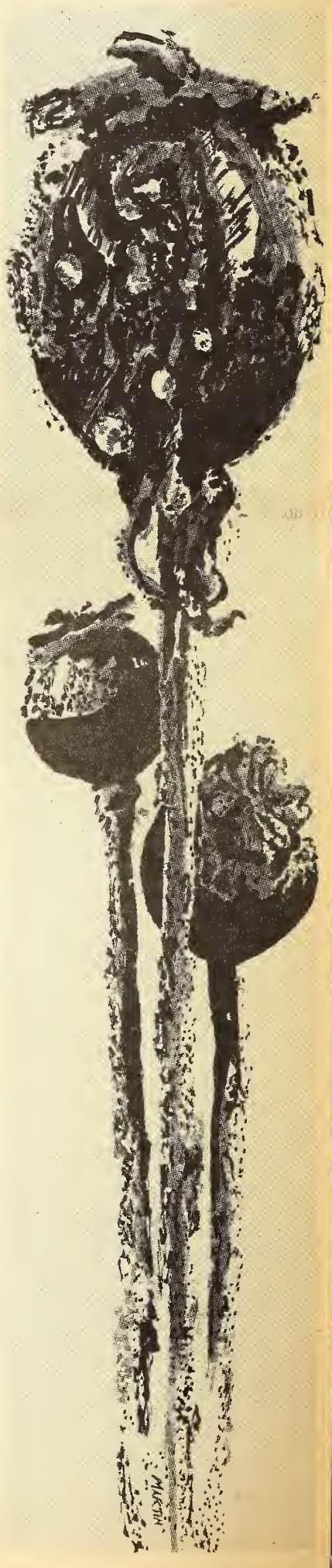
Today, both of these basic assumptions are being seriously challenged. Few would deny that the money needed to finance traditional health delivery system in North America is fast fading. At the same time, it is becoming more and more apparent that health technology by itself is inadequate to treat many of the health problems of North Americans. As in the hills of Thailand, housing, economics, and primary health care have as much or more to do with preventing illness and restoring health as care received in an institutional setting.

The difference, however, is that in many of the developing countries, basic health care is almost non-existent, while in North America the services that exist appear to be inappropriate to achieve the desired goals. As Mr Archibald says: "In the west we are faced with the problem of how to turn the existing system around.

"Marc Lalonde's New Perspectives in Health Care fits well with the current WHO philosophy, and Ontario's Ministry of Health seems very much in sympathy with it. The problem is that the establishment, the institutions, don't fit so well with it.

"To plan effectively and run any comprehensive health program, a sharing of information and a sharing of work is vital. Yet, today, vested interests in the North American system and the lack of resources provided for information exchange seriously hamper this sharing and show the result of our specialist, institutional orientation," says Mr Archibald.

"We don't have the resources simply to add new programs and approaches to the existing system. We have to replace inappropriate programs with ones that are low cost and effective. This will necessarily mean more comprehensive planning by governments and non-governmental personnel together with a wider utilization of existing community resources including a wide range of health workers who are not specialists."



The opium poppy

A key factor in rehabilitation programs

Alcoholic worker must trust his employer

By Tim Padmore

VANCOUVER — Howard's shop foreman knew the mechanic often drank heavily at home, but he also knew Howard had family problems and shrugged it off.

The foreman was annoyed though when Howard frequently called in sick on a Monday morning.

And when Howard, obviously intoxicated, accidentally sliced open a tool cabinet with a forklift, he was suspended — and referred to the company's alcoholism program.

But it was no good. By now, his family as well as his job was gone — and he didn't really trust the company program. He and his buddies at work suspected that talking to the company doctor about an alcohol problem was probably the surest way to lose a good job.

Three months later he was fired for good, out of the program and on his way to Skid Road.

That fictional vignette illustrates the problems facing industrial alcoholism programs here.

To the ever present problem of overcoming the stigma of being labelled an alcoholic is added the problem of promoting trust between worker and employer.

The programs themselves are often small and directed by co-ordinators cast without adequate training or support into a complex professional role.

In the past five years there has been a burgeoning of alcoholism programs in B.C. At last count there were 22 in operation or getting underway, most initiated within the past two years.

According to Vancouver alcohol researcher Ron Cutler, who has been studying the programs, a third of them are entirely management initiated and most of the rest have only peripheral union involvement.

An attempt is finally being made to bring enlightenment to the system.

ADDIX, the Alcohol and Drug Dependency Society of B.C. (formerly the Alcoholism Foundation) has foresworn its broader but more or less dormant interests and merged with Occupational Consultants for Alcoholism Control of B.C., an organization of industrial alcoholism program co-ordinators, to concentrate on initiating effective industrial programs.

Jack McNeil, president of the group and co-ordinator of CN railway's alcoholism program in Western Canada, outlined the major aims of the group in an interview with **The Journal.**

He said funds are being sought from the B.C. Alcohol and Drug Commission to set up a project — dubbed Interlock — which will provide expert help to firms that want to set up alcoholism project programs, particularly small firms.

Participation by all levels of government, from alcoholism agencies and from management and labor will be sought.

The major emphasis in setting up the programs will be to obtain union-management consensus before the program starts. It's hoped that as a result "occupational programs will come to be perceived in a positive light by the labor force," he said.

"One problem is the mystique, the coverup and protection. Unless you can change that you're not going to do very much.

"The way it is now we don't get people until a gun is put to their head."

Mr Cutler said another way to increase voluntary referrals is to broaden the scope of the service so employees can go for help with any kind of personal problem. Often alcohol will be behind the trouble, but the employee avoids having to admit at the outset he has an alcohol problem.

Getting an employee early often makes all the difference. His life is not so much disintegrated, and the company can be more flexible if only minor breaches of discipline have occurred.

"It's hard to get a guy back if he's actually been fired," said Mr McNeil, who noted that under the railroad's Rule G, which prohibits, for safety reasons, any use of alcohol or drugs on the job, firing is not all that hard to come by.

Alcan plan features a treatment contract

KITIMAT, B.C. — Union and management representatives have announced formation of a joint program here to curb alcoholism in Alcan employees.

A model of the kind of union involvement said to be necessary for early detection of alcoholism, the program provides careful checks and balances to preserve worker rights.

A treatment contract is worked out, with union help, for each employee diagnosed as alcoholic. It sets out the employee's rights under the union contract, the methods of treatment to be used, and sanctions that will be applied if there is no improvement.

Said Jim Brisebois, executive member of the Canadian Association of Smelter and Allied Workers: "At the moment a lot of guys are just sent home for the day if they've been drinking and are not disciplined, but this is not good — either for the company or for the affected individuals."

Alcan works manager Bill Rich said: "Our major concern in developing this program with the union is for the health and well-being of our employees and their families."

An estimated 6% to 8% of the 1,800 workers at the smelter here are thought to suffer from some degree of alcoholism.

Cocaine wrongly likened to marijuana

(from page 1)

lying psychopathology, a major problem in their lives. It is that they got started recreationally and it got away from them," Dr Smith added.

The results can be serious, especially if cocaine is used intravenously — psychological dependence and cocaine psychosis. Two abusers in his area have died recently from overdoses.

Dr Smith said most people, including cocaine users, do not appreciate the abuse potential. "The information around is that it is like marijuana and it is considered free of adverse reactions.

"It is, of course, a general central nervous system stimulant. While physically it does not produce addiction, psychologically it is fairly easy to become dependent on it."

Drs Wesson and Smith say in their report that laboratory studies of cocaine may be misleading. "In our opinion, current human administration studies use substantially less cocaine than the doses self-administered by users in a natural setting, thus further confusing the issue of safety since dosage is a major determinant of adverse drug effects."

Their findings substantiate the premise that the toxicity of cocaine could parallel that of amphetamine.

"We have seen cocaine-induced depressions, psychological dependence upon cocaine, acute anxiety reactions to cocaine, and cocaine psychosis. All of these effects are similar qualitatively to other CNS stimulants such as the amphetamines," the report continues.

The usual route of administration is intranasally. Cocaine powder is arranged in thin lines and inhaled, usually through a rolled dollar bill.

Some individuals will inhale cocaine every 10 to 20 minutes. "Cocaine can accumulate in the body and a state of extreme agitation, with increased suspiciousness, and even paranoid psychosis can occur."

In those wealthy enough to buy large quantities of cocaine, they have seen "a cocaine psychosis with associated violence, similar to the stimulation associated with the violence seen in the high dose amphetamine abuse drug culture."

In one patient, repeated inhalation had led to a perforated nasal septum.

The report cites the case of a wealthy law student who started inhaling cocaine recreationally. He was introduced later to the pleasurable, orgasmic "rush" that intravenous administration can produce.

Over several months "he escalated his intravenous cocaine use on a daily basis, injecting from approximately 1 pm to 7 am on a 15-minute to one hour repeated schedule, using approximately two grams of cocaine per night."

On one particular evening, his girlfriend had a series of seizures after injection and needed emergency treatment. The student had signs of cocaine psychosis: auditory hallucinations, definite visual hallucinations, and extreme paranoia with ideas of reference.

The student sought treatment and had a severe drug induced depression during the first week. Later, diazepam was given at night to control his anxiety. Eventually, he returned to daily intranasal use to deal with lethargy and reactive depression.

Dr Smith said detoxication is easy generally. "We give them a sedative hypnotic to deal with some of the associated anxiety, and then determine if there is a reaction depression or not, or a depression underlying the reactive depression. Usually there is not.

"We get them through the depression, and then usually counsel about the health consequences and deal with the reasons they got into it."

Drs Wesson and Smith said in the report they found people used cocaine in association with other drugs, very often in an upper-downer cycle.

The secondary drug is usually a sedative hypnotic which deals with some of the stimulant side effects of cocaine.

Inverviews with people arrested for drunk driving, and who had intoxicating alcohol levels, showed "they were using a stimulant in combination with alcohol and their intoxication was actually a result of a secondary drinking pattern with the primary social drug of the evening being cocaine."

The report concludes that cocaine should be considered a drug of moderately high abuse potential, similar to that of amphetamines, but with variables that at the moment prevent its widespread abuse.

"However, if the availability of the drug is at a substantially lower cost, or (if) certain social-cultural rituals endorsed and supported the high dose pattern, more destructive patterns of abuse could develop."

Dr Smith said while he is worried about the health consequences of cocaine use, that does not mean he wants continuation of criminal sanctions. "I vigorously support the decriminalization of cocaine in a victimless crime philosophy."

At the same time, he advocates, as does Dr Andrew Weil (**The Journal** February), the use of coca leaves for medical therapeutic purposes.

Low alcohol intake may affect pregnancy

(from page 1)

such as cirrhosis (Pequignot) and pancreatitis (Sarles) and that "it might be that women really do have an increased risk at relatively low levels of alcohol consumption."

The authors admitted there were a number of problems in interpreting the results, besides that of having to rely on avowed alcohol consumption.

In the first place, the study had not been designed primarily to study alcohol as a risk factor and questioning was rather succinct. Women were not asked, for example, about their aperitif and after-dinner consumption.

In addition, some of the numbers were quite small. While the risk of abruptio placentae appeared to be greatly increased in the drinking group, this was based on four cases (three women who drank exclusively beer, and one who drank both wine and beer).

Finally, the drinking group tended to differ from the other group in several other risk factors: the women were older, more likely to be single, had had more pregnancies, were less likely to have a profession, were of a lower social class, were heavier, and smoked more. However, regression analysis showed that drinking was a risk factor in itself, after correction for all these factors.

This was particularly true with smoking, they said. While an earlier analysis of the same pregnancies had shown that smoking, too, causes an increased risk of stillbirth due to abruptio placentae, "the role of alcohol remains after taking into account that of tobacco, and vice-versa."

In addition, the authors said, there seems to be a different mechanism at work: smokers did not have any decrease in the weight of the placenta whereas drinkers did.

Pardon requests could influence cannabis bill

New impetus to liberalize legislation

(from page 1)

jail for non-payment of fines, simple possession of cannabis would in effect become legal.

Whether the federal cabinet will allow the cannabis bill to proceed, let alone allow more changes, is still in question.

Part of the pressure to reform the legislation seems to be emanating from the bureaucracy of government which is currently being swamped with requests for pardons.

A large number of the pardon requests come from young people convicted of drug possession.

Last year the government had to approve an estimated 4,000 pardons. That represents a lot of leg work for the RCMP, who have to check each applicant out, and furnishes more paper work for the bureaucrats.

This year, some 7,000 pardon applications are expected, threatening to swamp the pardon administration.

The increase in pardon applications is a good sign in at least one way; more and more Canadians are discovering that they can erase the stigma of earlier criminal follies, but they have to wait a number of years and formally request the pardon.

Even with the pressures mounting to reform cannabis laws, most Ottawa observers are sceptical that the cannabis legislation (even in the form approved last year by the Senate or in an updated form) will see the light of parliament before next fall at the earliest.

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Comment

Unruly locks need styling

BC moves to streamline alcoholism service

By Tim Padmore

THE BC GOVERNMENT'S current attempt to comb the tangles out of the province's system of services for alcoholics is viewed here with relief — and crossed fingers.

Relief that a determined effort is finally being made to style the unruly mop. And crossed fingers, that the barbering should not be so rough that serviceable locks are lopped off or so timid that the worst tangles, requiring the most discomfort to remove, are let be.

What's been done is to divide the province into four regions, Vancouver and the Lower Mainland, Vancouver Island and the adjacent coast, Southeast and South Central BC, and Northern BC, each of which is to have a complete complement of services.

A complement means a detoxification unit, outpatient counselling, a residential treatment facility, and residential support services, like half-way houses.

The tidy pattern has some big holes in it at the moment.

"We are trying," Christine Rodgers, a member of the three person Alcohol and Drug Commission charged with carrying out the re-organization said in a recent interview, "to fill in the gaps in an orderly way so every region in the province is served."

Staff is being hired now for a new residential treatment centre in Prince George, to serve Northern BC, a 20-bed detox unit will be put into an unused building at a Lower Mainland school for the retarded, and a 30-bed residential treatment centre is being set up in the Vancouver area.

There are still serious deficiencies in outpatient counselling, however. A single counsellor serves the Terrace-Kitimat-Prince Rupert area; Castlegar and Trail have none; and other areas as well are shortchanged.

At the same time, the performance and the plethora of existing agencies, which the commission has in the past funded more or less willy-nilly, is being examined. Some — and not everyone would agree the most deserving — have already been dropped.

On balance, it's going to be expensive. Currently the commission invests two-thirds of its $5.5 million budget in alcoholism. Commissioner John Russell says the new program will cost substantially more, although "it certainly won't be twice as much."

That the province's Socred government has not yet emerged from its tight-fisted phase into pre-election openhandedness is a matter of some concern.

Some parts of the plan will definitely have to wait.

"When you're hiring people in this field you're often choosing people who are unqualified or who have no direct experience, or both," said Mr Russell.

"We would like the residential treatment centres to have a training capacity, but it's not realistic to imagine that will happen immediately."

Dr Rodgers said the treatment philosophy will be one of personal responsibility.

"The professionals will help you to help yourself; you're not going to just give yourself up to them and let them take over."

But beyond that, she said, the individual units will be allowed to set their own style in choosing treatment modalities.

Will it work?

Mr Russell said he hopes the alcoholism services will become more visible and more attractive.

"We hope to get a clientele where there is more hope of lasting intervention."

With only 5% of BC's estimated 80,000 alcoholics getting treatment, there is clearly a long way to go.

The attempt to pull together the bits and pieces of services in BC will have to include measures to increase the numbers of cross-referrals between agencies. Only about 10% of the 4,000 who got treatment last year in a detox unit, residential centre or outpatient counselling service were referred by another agency, indicating a tendency to dump clients once the resources of a given agency are exhausted.

"It's a problem we're addressing ourselves to," said Mr Russell, adding that planned regional seminars for agency staff should increase their awareness of each other.

When one compares the 4,000 who were treated with the estimated 80,000 alcholics in the province, it's evident the effort will not be wasted.

Oh to fly the smoke-free skies

By Harvey McConnell

AT PRESENT American aviation officials are wading through some 25,000 comments on a proposal to ban cigarette smoking on domestic airlines. Hopefully most are against the practice, and soon on boarding a plane one will not have to declare, almost like on a customs examination, "smoking" or "non-smoking."

It is a heartening sign that, at last, the right of the non-smoker is bearing fruit. It is also just: those who smoke are the perfect example of the minority abusing the majority.

Why should a smoker assume automatically he has the right to light up any time, anywhere, unless it is banned specifically? Smokers should be shamed into realizing that their habit stinks, literally, to millions of people.

Ironically, millions of dollars are poured into advertising deodorants, yet rank cigarette smoke is in a class of its own. There is nothing worse, even to the hardened smoker who has managed 30 minutes without a smouldering stick, to walk into a crowded smoke-filled room.

Much has been said and done about industrial pollution, but not enough about cigarette smoke pollution, which is just as important.

Aesthetics aside, the argument against cigarette smoking on health grounds is now beyond dispute in the minds of most rational people when they consider the evidence. As **The Journal** reported in January, male lung cancer deaths in England have fallen for the first time in 50 years, the first industrial country to report such a trend.

There is no question that anti-smoking propoganda is responsible in large part.

But if English men are realizing the danger, English, Canadian and American women are not, and their rate of smoking, and death, continues to rise. It is evident that major research is needed into this facet of behavior.

As the cost of health care soars, the burden, and there is no other word for it, that the smoker unfairly puts on the system is enormous. How many millions of dollars are spent in caring for the crippled victims of emphysema, much less for those who pay the ultimate price for such a folly in death from lung cancer?

It is scandalous that lawmakers in almost every country funk the issue, left, right, and centre.

Tax money from cigarettes is an enormous source of general revenue. Tobacco, unlike almost any other commodity, does not fluctuate in the amount poured into treasury coffers.

Paltry sums comparatively are put into prevention, and the tobacco tax bonanza continues.

A facile argument used by many legislators is that to cut cigarette consumption would affect tens of thousands of people, from farmers to workers in the manufacturing plants.

The same rationale is not advanced when it comes to control of other carcinogenic initiators, such as the asbestos industry.

It will be a long time before society as a whole gets its priorities right and demands action on a substance that is destructive in every sense.

If governments won't act, the individual must. Non-smokers should take the offensive in daily living, such as English actor Nicholas Parsons. If any dinner guest asks "do you mind if I smoke?" his instant reply is "yes."

(Mr McConnell is an inveterate smoker).

Inside Science

Pot offenders'

By Lorne Salutin*

"John J. Doe, you are charged that on/ or about the 16th day of May, 1976, in the Municipality of Metropolitan Toronto, in the Judicial District of York, you unlawfully did have in your possession a narcotic, to wit: Cannabis sativa, its preparations derivatives and similar synthetic preparations, namely cannabis marijuana, contrary to Section 3, Subsection 1, of the *Narcotic Control Act*, thereby committing an offence under Section 3, Subsection 2 of the said Act . . . John J. Doe, how do you plead? Guilty or not guilty?"

These imposing words, or similar phrases, have echoed through Canadian courtrooms more than 100,000 times since 1968, more than 25,000 times in 1975. One intended consequence of this sort of massive legal enterprise is deterrence. But what sort of unintended consequences befall the many Canadians who have been subject to this court procedure?

The employment opportunities of any offenders may be affected negatively by public knowledge of their criminal record. Most persons charged with possession of cannabis are young and are in many cases, unestablished in a career. The Le Dain Commission expressed concern about the stigma of a criminal record for cannabis possession experienced by young persons who would otherwise have had no record. No empirical studies have been done in this area until recently.

The Evaluation Studies Department of the Addiction Research Foundation of Ontario has just carried out a field experiment to investigate the role played by cannabis possession records in employers' consideration of candidates for vacant positions. The work supplements a larger study of the social consequences of the criminalization of cannabis offenders.

The experiment in part replicates earlier experiments on legal stigma by Palys and by Schwartz and Skolnick. Both of these studies introduced unwitting potential employers to "applicants", who were identical in all respects except for legal history which varied according to the experimental condition. "Applicants" had either an assault conviction and jail sentence, an acquittal or an assault charge, or no record at all.

One study represented "applicants" with a handwritten letter in response to classified help wanted advertisements. The other had the cooperation of a *bona-fide* personnel agent, who introduced the experimental "candidate file" to employers in the course of his normal activities and recorded their responses. Both studies found that, compared with controls, applicants with any criminal record, including acquittal, had significantly fewer positive responses from employers.

In contrast to the offence of assault studied previously, the Evaluation Studies investigation concerns possession of cannabis, a criminal offence under the *Narcotic Control Act*. Realism demanded that the most serious "record" to be studied should correspond with the most common outcome of the simple possession of cannabis charge, a fine. In Canada in 1975, only 4% of cannabis possession sentences were imprisonment, while 66% resulted in fines and 23% in discharges. A discharge is technically a lesser penalty

'Raise the drinking age? Hell, at this rate we'll never be adults!'

Letters to the Editor

A unique document

A few months ago the International Council of Women held its conference in Vancouver and one of our delegates now receives copies of **The Journal** which she passes on to me. For this gesture I am most grateful as I find the paper most informative and useful.

It was therefore with considerable pleasure that in the January issue I saw a reference to the Report of the National Council of Women (Great Britain) working party on "Alcohol problems of women and young people". I am chairman of the working party and the response to the report has been highly satisfactory — we are now having it reprinted for the third time which is something we had not anticipated.

NCW works at legislative level so we directed our thinking towards trying to influence the government and produced nine recommendations for them to consider. The report really fills in the background to these.

I am sending you a copy of the report as (somewhat to our surprise!) this is now being regarded a unique document. Roland Moyle MP, Minister of State at the Department of Health and Social Services has written through his Private Secretary, after having answered each recommendation separately, "The Minister would like to congratulate the National Council of Women on producing a valuable and interesting report on aspects of the problem of alcohol abuse which have not so far been extensively investigated".

The recommendation which I consider most important is that which asks for the setting up of a Permanent Commission on Alcohol Affairs. I found during our research absolute fragmentation of what was being done on the "alcohol front" and dissatisfaction at how government money was allocated.

We should be glad to send our report to anyone interested (at 2 dollars, post free). Some of it is being translated into Dutch.

With all good wishes for the continued success of your journal.

May W. Holland
The National Council of Women of Great Britain
Sunbury-on-Thames
Middlesex, England

Impact study a first

Thank you for the excellent coverage of the CSTAA sponsored impact study of the Uniform Alcoholism and Intoxication Treatment Act. Since this is the first systematic study of the impact of the Uniform Act we think it is the most important one in the field.

We appreciate the publicity you and Harvey McConnell have given the report in the Backgrounder of **The Journal**'s January, 1977 issue.

As a footnote, might I add that we are receiving delayed or forwarded requests for copies of the

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Backgrounder

Officials wary of linking NIDA and NIAAA

By Harvey McConnell

AN IMPETUS from Congress coupled with President Jimmy Carter's determination to scythe through the plethora of US government departments augurs that alcohol and drugs will soon share the same agency.

The question for officials at the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse is not only possible amalgamation, but also the direction a new agency would take. Would it be tipped more towards alcohol, which has become the major symbol of abuse?

President Carter's intentions to prune is allied to an interest in the whole substance abuse field. Peter Bourne, White House assistant with special responsibility for drug abuse and mental health, is experienced in running previous programs in Georgia.

In addition, there is the recommendation to the previous administration by the President's Biomedical Committee that research at NIAAA, NIDA, and the National Institute on Mental Health be separated and returned to the National Institute of Health which is noted for the quality of its investigations.

A major argument for the move is that when research is combined with service and training, the service dollars generate much more consistency, enthusiasm, and citizen group support.

There is in general no hue and cry for research, which galls many investigators as they feel this is the only way to find the answers, particularly those dealing with alcohol.

Any worry about the future is coupled with a worry about the past at NIAAA, and with worry about the report Ernest Noble, director, presented recently to the House Committee on Interstate and Foreign Commerce on grants and contracts to national organizations during the tenure of his predecessor, Morris Chafetz.

In light of the committee's request last year, a thorough and objective review of grants and contracts was made by a task force of 15 senior staff from the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), NIAAA, NIDA and NIMH.

Its findings were submitted to the citizen National Advisory Council for the agency. The council decided that in the majority of the 16 different grants no further funds be allocated when contracts expire.

The task force report on each grantee has been kept secret by Dr Noble under the Freedom of Information Act, despite determined efforts by the press to pry them loose.

It was as much fate as decisions that put NIAAA in such a position.

Dr Noble's report to the House committee points out that in fiscal year 1974 the institute had a regular appropriation of $139 million. Then an additional $80 million, which had been granted by Congress but impounded by the Republican administration, was released by the courts.

This windfall had to be administered "with a total permanent staff of less than 100, many of whom were clerical and support personnel," the report adds.

What happened is summed up by one of the country's leading alcohol researchers, who works far from Washington:

"I got a call asking if I wanted a supplement. They had to get rid of the money and they simply did not have a lot of people to staff it out.

"Looking back, government agencies do not turn money back, that is a cardinal rule.

"It might have been better to throw together some sort of peer review at the time, because peer review, even though it is a problem to get three people together at the same place at the same time, just keeps you out of trouble."

The institute now has a system of peer review.

Dr Noble's report said: "There is evidence that the office of the institute director (where the majority of the grants to the organizations originated) sometimes ignored or circumvented accepted policies and procedures for the review of project grant applications from national organizations."

The result was "the review procedures for many of the grants to national organizations were highly irregular and inconsistent in relation to the formal peer review process utilized for the institute programs of a more traditional and well-

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job chances studied

than a fine. Although both are awarded following a finding of guilt, the accused who receives a discharge is "deemed not to be convicted of the offence". The legal nature of the discharge is complicated: for purposes of the Criminal Records Act, it is treated as a conviction.

Combining aspects of the previous studies' methods, the investigation employed the following procedure. Persons representing themselves as potential applicants telephoned employers who had advertised vacant positions. The positions chosen were relatively unskilled and they all involved some degree of concern over "security". Less skilled vacancies were chosen because a sample of Toronto cannabis offenders showed that most of them held such jobs. The sample was selected from positions in which employers were likely to have a routine interest in whether potential employees had a criminal history.

The caller outlined his qualifications, always the same, then asked a question which varied according to the randomly assigned experimental condition. In the control or "nothing" condition, he simply asked if it was worth applying. In the other two conditions, he asked if it was worth applying in view of either his conviction and fine for marijuana possession, or his absolute discharge for marijuana possession. The employer's response was noted. A sample size of approximately 100 was obtained.

The results of this study are now being analyzed. Regardless of pending changes in the law, the social costs of the enforcement of the cannabis possession law deserve investigation. Legislative efforts to reduce the stigma of criminal records for simple possession of cannabis have centred on the introduction and use of the discharge provision. Yet, until recently, no systematic study of the differential impact of the discharge provision, compared to a conviction, had been made.

In their study, Schwartz and Skolnick assert that in relation to those responsible for the criminal justice system, results from this sort of research "might help to inform these decision-makers and perhaps lead to changes in substantive law as well".

*** (Mr Salutin is a senior research assistant in Evaluation Studies at the Addiction Research Foundation.)**

Data on cancer and smoking are 'unconvincing'

By Alan Massam

LONDON — Philip R.J. Burch is big, bald, and formidable, a distinguished lecturer at the Department of Medical Physics, University of Leeds, and easily the most persistent thorn in the flesh of Britain's medical anti-smoking lobby.

For Professor Burch has closely studied all the literature condemning the habit as a cause of cancer and emerged — to put it mildly — unconvinced.

In Britain there are few individuals with the inclination to challenge world-renowned epidemiologist Sir Richard Doll, who has regularly added evidence to the "smoking causes cancer" hypothesis (**The Journal**, January). Except Professor Burch that is.

Sir Richard's latest broadside (in which, with Mr R. Peto, he concluded a 20-year study of doctors' smoking habits) was claimed by the *British Medical Journal* of December 25, where the study was published, "to set out in detail the toll that smoking takes from human life in both mortality and lingering ill health."

Now Professor Burch has delivered his equally robust response in the BMJ of January 15. According to the watcher from Leeds, Sir Richard's tables reveal that the temporal trends in overall mortality show no consistent association with the trends of smoking habits.

Professor Burch says that in dealing with death rates from lung cancer the "abundantly documented complication of the unreliability of clinical diagnosis" has to be faced. It cannot be assumed that the accuracy of diagnosis of lung cancer in doctors is the same as that in the general population.

"I have shown that the detailed changes in recorded death rates from lung cancer in England and Wales from 1901 to 1970 were strikingly synchronous in the two sexes (*The Biology of Cancer. A New Approach.* Lancaster Medical and Technical Publishing 1976)," he says.

"Thus, the major cause of the increases had a simultaneous impact on both sexes and could not have been cigarette smoking because the increase in the consumption of cigarettes by women lagged some 30 years behind that of men."

The professor adds that post mortem studies of the frequency of lung cancer shows that the most important factor in the increase of recorded lung cancer has been clinical diagnostic error.

Severe underdiagnosis during the earlier part of the century was eventually followed, in the past decade or so, by overdiagnosis.

Professor Burch adds: "In view of the wide publicity concerning lung cancer and smoking and the knowledge that many doctors have given up smoking, the tendency of one doctor to make a false positive diagnosis of lung cancer in a colleague is minimal.

"Direct comparison between the temporal trends of mortality from lung cancer in doctors and the dissimilar population of all men in England and Wales, with dissimilar standards of diagnosis, is therefore inadmissible.

"That Professor Doll and Mr Peto should highlight this comparison is curious to say the least. Their regression line shows an average reduction in relative mortality (doctors versus all men) of about 60% over the period 1955 to 1971. Over the corresponding period, age-standardized recorded death rates from lung cancer in all men in England and Wales above the age of 40 increased by about a factor of two.

"In combination, the data suggest that the recorded and verified absolute death rates from lung cancer in British male doctors — which should be more reliable than those in the general population — have shown no significant temporal trend, either up or down, over the period 1955-71.

"The consumption of cigarettes by male doctors fell by more than 50% between 1955 and 1971. It appears doctors have derived little or no proved benefit with respect to lung cancer, or to all causes of death, by giving up cigarettes."

Professor Burch concludes that coupled with the finding that the risk of lung cancer is less for inhalers than for non inhalers, it is therefore difficult to accept that lung cancer is due to cigarette smoking.

Professor Burch, who is 57, has often been accused of irresponsibility following his not infrequent attacks on the anti-smoking lobby, but he shrugs off such charges. He has been quoted as saying there is nothing heroic in taking on the medical establishment since physics, his specialty, is the most advanced of the natural sciences whereas medicine is the least advanced.

"It would have been cowardly to have dodged the issue," he says. "I concluded that natural cancer arises as the result of genetic changes. Then I found that none of the possible mechanisms whereby smoke might cause cancer was consistent with the statistical evidence. And I was staggered. I wrote a series of articles to *The Lancet* because I wanted to test the reliability of my conclusions and the discussion which followed was quite inadequate. I believe that was because of the weakness of the theory that smoking causes lung cancer."

The anti-smoking-lobby scientist is not, however pro smoking. He is a non-smoker and does not suggest the habit is healthy — only that the suggested link between it and lung cancer is unproven.

Health minister voices concern

UK women increase alcohol intake

LONDON — Britain's health minister, David Ennals, has shown he is particularly concerned about the growth of alcohol and tobacco consumption among women.

He told a meeting organized by the National Joint Committee of Working Women's Organizations that he felt these problems were particularly serious for pregnant women.

"All the available evidence indicates the number of people with alcohol or alcohol related problems is increasing in nearly all sections of the population," he said. "But the rise is particularly serious among women. I suspect that in the past, women who developed drinking problems were often reluctant to seek advice and indeed advice hasn't always been easy to get.

"But in recent years, we have encouraged the setting up of compassionate and confidential services so that help is available to those who need it. I would urge any woman who thinks she has a drinking problem to contact her general practitioner or any of the voluntary organizations which help alcoholics — and to do so without delay."

Mr Ennals said the connection between heavy drinking in pregnancy and malformation of a subsequent baby had been shown by recent studies.

"The evidence so far suggests fetal abnormality may result from the sort of drinking done by advanced alcoholics rather than social drinkers," he added.

"But in view of the seriousness of the matter, I shall ask the Advisory Committee on Alcoholism (group of independent experts set up to advise the Government) to give me an opinion on the evidence available so far and officers of my department will continue to keep a close eye on the situation.

David Ennals

"If pregnant women gave up smoking this would probably do more to contribute towards a successful birth than anything else they could do. Smoking mothers tend to have small babies — often premature — with a higher than normal risk of illness and death. It is estimated that about a thousand more babies each year would survive if mothers did not smoke during pregnancy."

British youths feel forced to become drinkers

LONDON — Young people in Britain today are under great pressure "to accept alcohol as almost a vital part of life," contends Derek Rutherford, director of the British National Council on Alcoholism.

He told a conference of the Royal Society of Health on juvenile drinking: "It can be said that we have arrived at the antipode of the situation 50 years ago.

"Drinkers, owing to prohibitionist pressures, had to fight for their right to drink. Now, non-drinkers have to exert their right not to drink.

"In a recent survey, 75% of self-defined problem drinkers claimed their condition was due to sheer social pressure and their response to conform to it. Today's environment is less supportive and more permissive."

Mr Rutherford said that since 1973, one-fifth of all problem drinkers who came to alcoholism information centres were under age 25. Admissions to hospitals with a diagnosis of alcoholism in the same age group have climbed consistently over the past decade.

"A most disturbing aspect of this trend is evidence of an increasing number of young persons under 14 being diagnosed with an alcoholic problem," he added.

However, Mr Rutherford cautioned that the present situation in Britain must not be over-exaggerated.

"A large number of young people who are experiencing some present problem or difficulty with their drinking will check it before there is any likelihood of increasing their morbidity from various diseases or dependence associated with alcohol.

"The majority will come to terms with alcohol, successfully work their passage from adolescence to adulthood, find identity, and begin to accept family responsibilities."

Mr Rutherford said present cultural attitudes reinforce social acceptability and mask the genesis of an excessive drinking problem.

"It can be said that excessive drinking is culturally inflicted. The early recognition of a problem drinker is camouflaged by the 'excess' of the drinker who can hold his liquor."

Sex life impaired by alcohol abuse

AUCKLAND, NZ — Alcohol abuse is the commonest cause of the first episode of secondary impotence among men in the United States, according to Domeena C. Renshaw, associate professor of psychiatry and director of the sexual dysfunction clinic at Loyola University of Chicago.

"When a man comes to you with impotence, please get a good history. Ask him how much alcohol there was on the very first time," she advised doctors attending a conference of the New Zealand College of General Practitioners.

Six ounces of hard liquor or the equivalent of beer will cause a partial erection in a male, Dr Renshaw said.

Domeena Renshaw

"If he's upset about that, he'll lose it completely. If he sleeps through the night for four hours or so he'll metabolize the alcohol and if he tries in the morning he'll be able to function.

"They usually don't do this. They go to work. They come home. They drink four on the way home, a few more before supper, a couple after, and one just before bed. They try intercourse, the whole cycle repeats itself, and we really have a problem."

She said chronic alcoholism does something different, causing retarded ejaculation at a certain phase before a male has permanent impotence.

Dr Renshaw said some pharmaceutical drugs, particularly Valium, interfere with sexual functioning by preventing climatic responses in women and causing potency problems in men.

Antihistamines, antihypertensives, and apparently nicotine, can also affect sexual performance, she added.

Around the World

Tokyo tea

A Tokyo-based tea company claims it has produced a blend which will help stop smoking. Mixed with two kinds of nuts, the tea tastes like a mixture of coffee and a Japanese wheat-roasted tea and is light brown in color. A spokesman for the Kaiyo Bokujo Company said tests have proven the blend to cut the desire to smoke, but adds the company has yet to discover how this happens. The tea is actually grown in China's Yunnan Province on the Indo-Chinese Peninsula.

Drought to drink

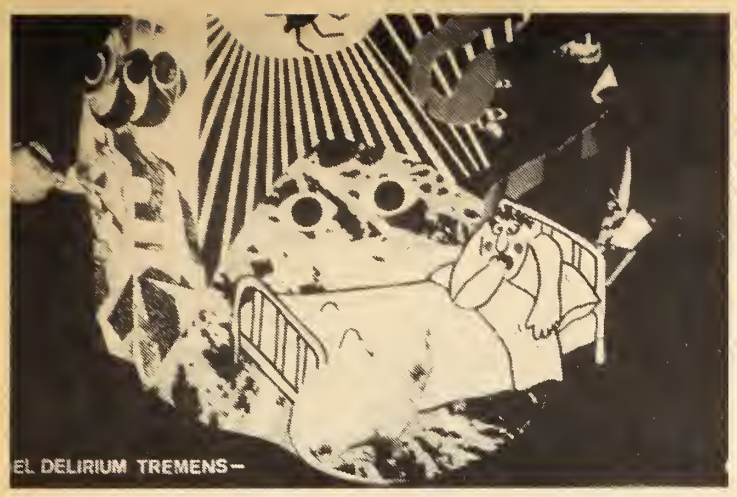
Britain's drought last summer helped the country's beer drinkers to down a record 11.55 billion pints (1.65 billion gallons) of beer during 1976. The brewers reported recently that they produced more than 40 million barrels last year compared with 39 million during 1975.

Smoking kids

Northern Ireland is the only place in the United Kingdom where boys and girls under the age of 16 can legally buy cigarettes — even a toddler could be sold them. A campaign to put an end to this anomaly has been launched by the Ulster Cancer Foundation which has produced a draft bill to be put before the Government. Pending the introduction of legislation the foundation is appealing for a voluntary code by retail tobacconists under which they agree not to sell cigarettes to anybody under 16.

OBE

A New Zealand doctor has been honored by the Queen for his work in the treatment and rehabilitation of alcoholics. Thomas Maling was made an Officer of the British Empire in the New Year Honors List. Dr Maling, a New Zealander who trained at Cambridge University and St Thomas' Hospital, London, has for 34 years been on the staff of Queen Mary Hospital at Hanmer Springs, a public hospital which runs an impatient treatment program for alcoholics.



The Spanish Ministry of Health is spreading the word about the dangers of alcohol with posters. (Left) 'El delerium tremens' translates easily, while the poster on the right means 'The most common addiction today is alcoholism.'

The disease may affect 5 million people

Spain's economy being crippled by alcoholism

By Larry Scanlan

MADRID — Alcohol-related industries are still kingpins in the Spanish economy and the cafe-bar is still an integral part of this society. But alcoholism is starting to hurt the economy and there are signs that the Spanish government is worried.

In the June 1976 issue of *Revista del Instituto de la Juventud*, a publication issued by a government department concerned solely with the young, a Spanish authority on alcoholism comments that alcohol addiction in Spain now constitutes a grave socio-medical problem. And the trend is towards younger addicts.

Joaquin Santo-Domingo noted that among European nations, only France consumes more alcohol, adding that there are now an estimated 1.5 million alcoholics in Spain. These alcoholics, he said, directly affect another four or five million people. Dr Santo-Domingo, who is professor of psychiatry at the University of Madrid, also suggested that alcoholism costs the Spanish economy at least 20,000 million pesetas annually, or almost $300 million.

Spanish youths, it appears — especially Spanish girls — are also drinking more.

Dr Santo-Domingo reported that while in 1968 only 3% of alcoholics in a Madrid treatment centre were between 16 and 25 years old by 1974 the figure had more than doubled.

In that same treatment centre, young female alcoholics made up only 0.5% of addicts in 1968; by 1974 this figure had risen to 2.5%.

Dr Santo-Domingo said adolescent drinking in Spain seemed to be part of the 'passage rite' into adulthood and may be an important step on the road to eventual addiction.

Although alcohol dependency in children is rather rare, he said hospital emergency departments frequently deal with acutely intoxicated children and alcohol treatment centres have admitted children as young as four years old. There is no 'drinking age' in Spain so, in theory at least, a very young child could be served in a bar.

Octavio Aguar, a doctor of pharmacy with the drug bureau of Spain's national ministry of health, told **The Journal** that while the volume of drinking in Spain has not appreciably changed since the 1940s, drinking habits have. The opening of Spain to tourism, he said, also introduced hard liquor, and much of the alcohol-related advertising in Spain today promotes products other than wine or beer.

Dr Aguar, who in addition to administrative duties in the health department, analyzes caches of drugs seized by Spanish police, further commented that 'brown sugar', a heroin which includes amphetamines and barbiturates, has recently appeared in Spain.

Heroin, he explained, was previously difficult to find in Spain, but since July of last year, small quantities of 'brown sugar' are being confiscated by the police.

Cannabis use in Spain, according to police statistics, is increasing, but Dr Aguar stressed that police data are obtained from a wide variety of sources — including people being detained for drug use — and cannot be relied upon to give a true picture of drug use.

However, the total amount of drugs seized by Spanish police in 1975 was six million kilos, rising to seven million kilos in 1976. Whether this signifies increased drug use or greater police diligence, remains a question mark.

Dr Aguar's personal opinion was that Spanish police had slightly softened their stand on drugs in the last one or two years, at least on first time cannabis users. Spanish law has not changed, he said, only its application.

He said Spanish police had, in the past, held the notion that *all* drug use was equally condemnable and dealt harshly with any sort of abuse. Widespread education of the police has enabled them to make distinctions they could not make in the past, he noted.

What is Spain's health ministry doing about addiction? Dr Aguar said a government commission formed in 1972 to deal with addiction met recently to discuss a project which could mean the building of three major alcohol addiction treatment centres, along with research facilities. They are now awaiting a government decision on funding.

Recognizing the problem of adolescent drinking, the government has also forbidden alcohol advertisements on television during children's prime time of 5 pm to 8 pm.

The government's youth bureau, meanwhile, has recommended a massive education program on alcohol use aimed at the young should be undertaken. Among its recommendations, drawn up last summer, is one urging restrictions on alcohol advertising which uses testimonials by sports figures, well known artists, or others whom young people might emulate.

But the program to control alcohol abuse in Spain has begun slowly, Dr Aguar emphasized. To move too quickly, he admits, would be to deal a death blow to the Spanish economy.

Anti-barbiturate campaign effective in UK

By Alan Massam

LONDON — British doctors are increasingly thinking twice before prescribing barbiturate sleeping tablets, thanks in no small measure to the efforts of a unique professional body — the Campaign on the Use and Restriction of Barbiturates.

Formed 18 months ago with the backing of the British Government, CURB has reinforced an existing decline in the use of barbiturates (as newer and safer drugs were introduced) by lecturing in medical centres and making postal shots to individual medical practitioners.

CURB's chairman, John Bennett, a family physician from the provincial town Hull, acknowledges that some of these postal approaches suggesting doctors should voluntarily restrict their barbiturate prescribing have been "like waving red rags in front of bulls." But he insists that on the whole, the five postal approaches so far — whether informative, cajoling or exhorting — have had "a highly desirable impact."

'Many more doctors are prescribing barbiturates for no new patients and many are weaning habituated patients off them.'

Dr Bennett told a recent conference to introduce CURB's latest publication, a leaflet suggesting ways patients might sleep better without barbiturates, that he could not *prove* that the campaign was beneficial.

"The only signal of the campaign's effect will be a change in the number of prescriptions given per year," he said. "We know that the number was already declining before the campaign began, and only if it shows a marked downward swing can we claim success.

"Figures for prescribing inevitably take some months to collate after the prescriptions themselves have been dispensed by pharmacists, and it will be some time after the campaign has closed down before we shall know just how effective it has been.

"There are straws in the wind, however. Informal (and therefore unmeasured) contacts suggest that many more doctors are prescribing barbiturates for no new patients and that many are weaning habituated patients off them.

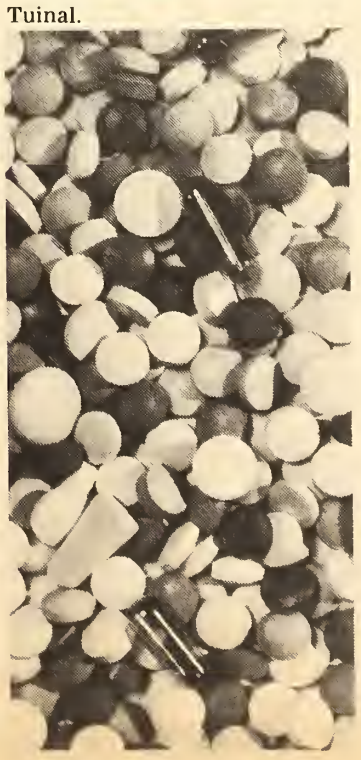
"Pharmacists here and there report a drop in usage. Questionnaires, at least to psychiatrists, geriatricians, and general practitioners in some parts of the country, show that the use of barbiturates has diminished or been given up."

Dr Bennett said it was hoped CURB would have completed its campaign after two years and that a clear indication of its success or failure would be available by the beginning of 1978.

"But whatever has been achieved over prescribing figures, the problems will continue," Dr Bennett warned.

"Barbiturate abuse among the young continues, and is no less worrying now than when we began," he said. "Police, probation officers, and social workers still have to cope with this, but we hope that we can say that they are no longer being hindered by any unawareness of the problem on the part of the medical profession."

Professor J. D. P. Graham of the Welsh National School of Medicine recently reviewed the place of barbiturates relative to the newer tranquillizers and hypnotics now available, and noted that those most commonly prescribed in Britain were amylobarbitone, butobarbitone, quinalbarbitone and the mixture Tuinal.



He noted there were more than 90 preparations containing barbiturate available for prescription so doctors might well be prescribing them unwittingly, and in 1973 there were 71 million prescriptions for psychoactive drugs issued in England and Wales alone, 8.8 million being for barbiturates uncombined with other drugs.

Professor Graham said barbiturates were the cause of admission to hospital of some 10,000 patients annually suffering from self-poisoning (in England and Wales) and that some 1,700 deaths occurred as a result of barbiturate poisoning.

Among those who died from barbiturate overdose were people found dead at home, frequently from a combination of barbiturate and alcohol or other sedative.

"The three H's are responsible," he said, "hypoxia, hypovolaemic shock and hypothermia." Benzodiazepines were also a frequent cause of admission to hospital, but deaths from these drugs alone were very rare and treatment was simple.

As less toxic alternative hypnotics to barbiturates, Professor Graham suggested nitrazepam or flurazepam, chloral hydrate, dichloralphenazone, ethchlorvynol, methylpentynol, methyprylone and triclofos.

As less toxic sedatives, he suggested the numerous benzodiazepines, which were "very rarely lethal except possibly when alcohol and nitrazepam were combined" had very few side effects, might interfere rather less with the quality of sleep, were relatively weak enzyme inducers (whereas barbiturates are powerful inducers of liver enzymes which degrade other drugs) and as yet had not given rise to a problem of addiction or abuse.

'Barbiturates are responsible for the majority of admissions to mental hospitals for drug dependent persons.'

Professor Graham said the gains from reducing the prescribing of barbiturates (CURB is not concerned incidentally about their use as anaesthetic agents or with phenobarbitone as an anticonvulsant) were in the fields of patient care (fewer deaths, hospital admissions not so necessary, treatment easier) and community care (less stocks held in pharmacies, fewer breakins, less available for misuse which reduces the load on police and social and medical services.)

CURB claims in its literature that a survey of admission to mental hospitals shows that patients admitted with a diagnosis of drug dependence (in 1973) are most likely to be dependent on the barbiturate group. In fact the barbiturates are "easily the commonest group of drugs responsible in both teenagers and the over 40s." The campaign adds that police and social workers are keen to bring in controlling legislation to restrict the prescribing of barbiturate preparations.

ARF favors global approach to program design

By Karin Sobota

TORONTO — The Addiction Research Foundation of Ontario's continued contribution to the health and welfare of the province's residents can be achieved best through a modified, systematic design of the ARF's programs.

John B. Macdonald, president of the Foundation since September 1976, told a seminar here a global approach by the ARF towards individual issues in the field is a favored alternative to a "piecemeal accumulation of projects which are the creation of individuals, often working in isolation from one another."

In observing the work of the Foundation since his arrival, Dr Macdonald said he was "encouraged and impressed by the ARF's total program." However, he noted there is little agreement either outside the Foundation or within "about what constitutes good treatment, particularly in the field of alcohol."

"It strikes me as a little extraordinary that after 25 years of existence of this Foundation, there is so much disagreement about what constitutes 'best'." This disagreement, Dr Macdonald said, was one of the reasons for the establishment of the Task Force on Treatment Services — to attempt to develop an approach to treatment which recognizes there are distinctive populations with individual needs and in so doing, develop a set of standards of practice and requirements of service units to meet those needs.

"The task will involve some arbitrary professional decisions because of the inadequacy of the scientific base on which to make any ultimate judgements," he said. "We need to digest and evaluate the world-wide literature on the subject along with our own experience to try to decide what is best at the present time. It is important because the public requires service and we can do better than we have done."

Dr Macdonald said he was attracted to Marc Lalonde's (national Minister of Health and Welfare) "health field concept" which embraces almost every aspect of the field of health. The first is human biology, a second category is environment, a third is lifestyle, and the fourth is health care organization.

"Alcohol as a component of the health field can be similarly examined although that hasn't been done ... The health field allows us to look at alcohol in terms of lifestyle, (social patterns, the acceptability of overindulgence, vocational pressures to drink, peer group social pressures etc), environment, (easy access, lower drinking age, seductive advertising, pricing, numbers and variety of outlets), or human biology," Dr Macdonald explained.

"In the field of health care organization, alcohol problems are concerned with case identification, treatment methods, standards, the training of manpower and so on. An analysis of this kind could help us identify the dimensions of various aspects of the problem and areas of opportunity where there may be a chance for us to have an impact.

"For example, the opportunities which exist in primary prevention may be limited. That is not to say there is not a case for research concerned with primary prevention but it is to question whether we have the knowledge which would justify mounting a massive attack aimed at primary prevention with the expectation that the results would warrant the effort. It is easy to say that prevention is better than cure, but we have to ask — 'Is prevention a realistic goal?' "

The Task Force on Treatment Services is a beginning, said Dr Macdonald, and he proposed the Foundation approach other issues by setting up similar expert task forces during 1977 and 1978 — on issues such as employee assistance programs, chronic drunkenness offenders and alcoholism among native people.

"When expert task forces have developed preliminary plans, their thoughts should be exposed in workshops which would bring together all the Foundation's experience to examine the issue in depth with the ultimate aim of proposing the most effective, comprehensive, coherent attack on the program"

Review is objective

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defined nature in the training and research area."

The institute has now a policy for objective review which requires a formally chartered review committee, composed primarily of non-government experts, to survey all competing project grant applications.

The director of one of the organizations that had the National Advisory Council call for an end to funding, is fighting to have the grant extended.

He said: "I think the task force report to the National Advisory Council exhibits some misconceptions of the facts that in our case could have biased the council to say no extension.

"We asked to correct these inaccuracies and to tell our story to the council. We are also asking for our grant to be extended."

Because of the fuss the general report has generated already, the director, while wishing to put the record straight, does not want to create such a fuss that it would affect NIAAA adversely.

Under the system the NIAAA director does not have to follow a council recommendation that an organization be funded. However, he cannot overrule a recommendation by the council that funds not be granted.

Dr Noble in his report said six specific program management improvements are planned in the near future. These include:

- Establishment of a committee to review all grant applications in the prevention, education and information area.
- Increased training of institute staff with regard to the review and monitoring of grants and contracts.
- Development of improved review, funding and evaluation criteria for use by outside reviewers, staff and applicants in the review and evaluation process.
- Improvements of methods to inform the public on an equitable basis of what funds are available, for what purposes, under what terms and conditions, and the process for applying for funds.
- Development of a policy limiting the scope of demonstration projects and requiring pilot testing before large scale funding.
- Development of standards for use in evaluating the performance of all grantees.

Letters

(from page 9)

report and/or the executive summary. Could you please advise your readers that the Executive Summary (Vol. 1) is available for $2.00 and the Guidance Manual for the Implementation of the Uniform Alcoholism and Intoxication Treatment Act (Vol. 2) for $15.00 from the Information Services Desk, CSTAA, 1101 15th St., Suite 206, Washington, D.C. 20005.

Thomas E. Price, PhD,
Executive Director,
Council of State & Territorial Alcoholism Authorities, Inc.,
Washington, D.C.

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CUT THIS ONE AND MAIL

New Books

by RON HALL

Sensual Drugs: Deprivation and Rehabilitation of the Mind

. . . by Hardin B. Jones and Helen C. Jones

Based on the author's transcripts of lectures, notes of interviews, and drafts of other materials, this book examines the effects of drugs on the stimulation of sexual sensations, the alteration of sexual responses, and the impairment of sexual functions. It is intended both for the drug user and those who have to deal in practice with the problems associated with drug use. Topic areas include: the action and hazards of sensual drugs, sexual deprivation, rehabilitation, drug abuse among American soldiers in Southeast Asia, and a separate chapter is devoted to marijuana.

(Cambridge University Press, 32 East 57th St, New York, NY, 1977. 382p. $3.95 — paperback $15.95 — hard cover.)

A Manual for Vocational Rehabilitation

. . . by Geoff Green, John Halliday, Fred Miranda, William Morris, Veta Mott, Steve Rosen, and Gary Tamkin

This manual has been prepared for those working in treatment programs, social service agencies and funding agencies, and is a collection of tested and proven ideas and concepts dealing with vocational rehabilitation of drug users. The contents include chapters on vocational rehabilitation during treatment, the role of the treatment program in re-entry, developing jobs for ex-substance abusers, adjustment issues and cooperation between agencies.

(Division of Drug Rehabilitation, Massachusetts Department of Mental Health, 190 Portalnd St., Boston, Mass, 02114. 1976 40 p.)

Drug Education: Results and Recommendations

. . . by Richard H. Blum

On the premise that drug education is and will continue to be important and that drug education can be a strong influence on children's drug conduct, this book presents a four-year study of the effects of drug education and offers strategies for educators to apply in their communities. The author comments that drug education is simultaneously productive, nonproductive, and counterproductive in that it restricts the extreme spread of drug use among young people and retards the intensity and variety of nonmedical psychoactive drug use; it makes no noticeable impact on students in grades two-three, or nine-12; and it destabilizes existing drug habits, including abstinence, among young people in grades six-eight. It is concluded children will move into adult drug use habits regardless of drug education programs and it is hoped that this movement can be controlled so the costs are not too high during the developmental years.

(D. C. Heath and Company, 125 Spring St, Lexington, Massachusetts, 02173. 1976. 230p. $14.50.)

To Your Health: The Pleasures, Problems, and Politics of Alcohol

. . . by Richard S. Shore and John M. Luce

With the purpose of increasing society's awareness of and respect for alcohol, the authors provide an account of the history of the drug including the development of alcoholic beverages and various political efforts to regulate them, including prohibition. The action of alcohol on the body and the health consequences of overindulgence are discussed, and current drinking practices are described. The authors present evidence that alcoholism is not necessarily a disease and suggest a problem-drinking model. They conclude with recommendations for the prevention and treatment of drinking problems.

(The Seabury Press, 815 Second Ave, New York, NY, 10017. 1976. 230p. $12.95.)

Empirical Studies of Alcoholism

. . . edited by Gerald Goldstein and Charles Neuringer

This book represents an attempt to understand the alcoholic through objective methods by examining the results of scientific research. The contributors report on the tension-reduction theory, perceptual and cognitive abilities in alcoholics, behavior modification techniques, as well as neuropsychological aspects. Although many advances are reported, numerous questions are left unanswered and disagreement remains concerning several alcohol-related issues.

(Ballinger Publishing Company, 17 Dunstar Street, Harvard Square, Cambridge, Massachusetts, 02138. 1976. 284p.)

Other Books

The Biology of Alcoholism — Kissin, Benjamin, and Begleiter, Henri (eds). Plenum Press, New York, 1976. "Volume 4: social aspects of alcoholism;" alcohol use in tribal societies; anthropology; drinking behavior and problems; alcohol and youth; alcohol and the family; alcoholic personality; alcoholism and mortality; crimes of violence; injury; employment; education; legal restraint. 643p. $43.10.

The Heroin Epidemics: A Study of Heroin Use in the United States, 1965-75 — Hunt, Leon Gibson, and Chambers, Carl D. Spectrum Publications, Inc, New York, 1976. Incidence of new users; prevalence; treatment and prevention; appendixes. 145p. $13.95.

Bad Trips. Freakouts, Overdoses: Emergency Treatment of Drug Crises — Health and Welfare Canada, Ottawa, 1976. 45p.

Studies of the Effectiveness of Treatments for Drug Abuse. Volume V: Evaluation of Treatment Outcomes for 1972-1973 DARP Admission Cohort — Sells, S. B., and Simpson, D. Dwayne (eds). Ballinger Publishing Company, Cambridge, 1976. Figures; tables; index. 522p. $17.50.

Psychoactive Drugs and Social Judgement: Theory and Research — Hammond, Kenneth R., and Joyce, C.R.B. (eds). John Wiley and Sons, Toronto, 1975. Problem; theory; method; empirical studies; new directions; indexes. 278p. $18.25.

Physiological Disposition of Drugs of Abuse — Lemberger, Louis, and Rubin, Alan. Spectrum Publications, Inc, New York, 1976. Principles of drug distribution; amphetamine; mescaline; LSD; morphine; barbiturates; caffeine; nicotine and alcohol; cannabinoids; cocaine; tolerance; index. 401p. $29.50.

Behavioral Pharmacology: The Current Status — Weiss, Bernard, and Laties, Victor G. (eds). Plenum Press, New York, 1976. Environmental influences affecting voluntary intake of drugs; interactions of behavioral and neurochemical processes; behavioral toxicology; reinforcement as determinant of drug response; index. 301p. $45.45.

Loss Control Management — Bird, Frank E. Jr., and Loftus, Robert G. Institute Press, Loganville, 1976. History; philosophy; case and effects of loss producing events; economics; measurement tools; evaluating performance; motivation; health; air pollution; loss control program for alcoholism; security. 562p. $16.50.

Empirical Studies of Alcoholism — Goldstein, Gerald, and Neuringer, Charles (eds). Ballinger Publishing Company, Cambridge, 1976. Alcoholism treatment; perceptual and cognitive deficit in alcoholics; tension-reduction models; neuropsychological studies; tables; figures, indexes. 270p. $18.40.

Behavioral Treatment of Alcoholism — Miller, Peter M. Pergamon Press, Toronto, 1976. Assessment; aversion therapy; teaching alternative behaviors; operant approaches; marital interaction; controlled drinking; indexes. 188p. $6.60.

Alcohol: The New Teen-Age Turn-On — Blakeslee, Alton, and Sullivan, Brian. Associated Press, New York, 1975. Society; reasons for drinking; peer pressure; law; education; research; treatment. 38p. $1.25.

Drugs of Concern in New Zealand — Simpson, David. Welsh University of Waikato, Hamilton, 1976. Concepts; CNS depressants; narcotic analgesics; CNS stimulants; psychotomimetics; references. 87p.

Trip Into Illusion: Misuse of Drugs by Adolescents — Wotzel, Horst. The Grail Message Foundation Publishing Company, Stuttgart, 1975. Extent of the problem; road to dependence; problem of dependence; human image. 68p. $10.

Rx: 3x/week LAAM Alternative to Methadone — Blaine, Jack D., and Renault, Pierre F. (eds), National Institute on Drug Abuse, Rockville, 1976. Preclinical studies; clinial studies. 126p.

Understanding Alcohol and Alcoholism in Scotland — Scottish Health Education Unit, Edinburgh, 1975. Consumption; prevalence; causes; effects; prevention; treatment; references. 23p.

The Young Driver Paradox — Warren R. A., and Simpson, H. M. Traffic Injury Research Foundation of Canada, Ottawa, 1976. 12p. $3.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Health Research Ontario — March 4-5, 1977, Toronto, Ontario. Information: Bill Gilliland, Addiction Research Foundation of Ontario, 33 Russell St, Toronto, Ont, M5S 2S1.

Detox Workers Training Program — March 7-11, 1977, Toronto, Ontario. Information: Diane Hobbs. coordinator, Detox and Rehabilitation Programs, 33 Russell St, Toronto, Ont, M5S 2S1.

1st International Congress on Toxicology — March 30 - April 2, 1977, Toronto, Ontario. Information: Robert G. Burford, G. D. Searle and Company of Canada Ltd, 400 Iroquois Shore Rd, Oakville, Ont.

INPUT 77: 2nd National Conference on Occupational Alcoholism and Drug Abuse — May 1-4, 1977, Ottawa, Ontario. Information: Phyllis Buirds, Humber College, Conferences and Seminars, Centre for Continuous Learning, PO Box 1900, Rexdale, Ont, M9W 5L7.

The Chemically Dependent Woman: Recognition, Referral, Rehabilitation — June 4, 1977, Toronto, Ontario. Information: Heather Rowe, The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 321.

The Canadian Medical Association and Quebec Division Annual Meeting — June 19-24, 1977, Quebec City, Quebec.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections 1977, Box 1450, Main Post Office, Calgary. Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference Headquarters, c/o The Portage Institute, 3418 Drummond St, Montreal, Quebec.

US

American Society for Pharmacology and Therapeutics — March 24-25, 1977, Dallas, Texas. Information: American Society for Clinical Pharmacology and Therapeutics, 1718 Gallagher Rd, Norristown, Pennsylvania, 19401.

National Association of Black Social Workers 9th Annual Conference — April 6-9, 1977, New Orleans, Louisiana. Information: Family Service Association of America, 44 East 23rd St, New York NY, 10010.

American Orthopsychiatric Association 54th Annual Meeting — April 13-16, 1977. New York City. Information: The American Orthopsychiatric Association Inc, 1775 Broadway, New York, NY, 10019.

National Council on Alcoholism-American Medical Society on Alcoholism 8th Annual Medical-Scientific Meeting — May 2-4, 1977, San Diego, California. Information: Frank A. Seixas, National Council on Alcoholism, 733 Third Ave, New York, NY, 10017.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

American Medical Association Annual Meeting — June 18-23, 1977. San Francisco, California. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illinois, 60610.

1977 New England School of Alcohol Studies — June 19-24, 1977, Colby College, Maine. Information: Jan Swift Durand, coordinator, PO Box 11009. Newington, CT, 06111.

6th Ohio Drug Studies Institute — June 21-24, 1977, Westerville, Ohio. Information: Jim Shulman, Ohio Bureau of Drug Abuse, State Office Tower, 30 East Broad St, Room 1352 A, Columbus, Ohio, 43215.

35th Annual Session of the Summer School of Alcohol Studies — June 26-July 15, 1977, Rutgers University, New Brunswick, New Jersey. Information: Summer School of Alcohol Studies, Rutgers University, New Brunswick, NJ, 08903.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Center, McLean Hospital, 115 Mill St, Belmont, Mass, 02178.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse and Smoking" — July 27-29, 1977, Seattle, Washington. Information: Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, Seattle, Wash, 98195.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977 — Honolulu, Hawaii. Information: Rosa Torres, Congress coordinator, 6th World Congress of Psychiatry, 1700 18th St NW, Washington, DC, 20009.

1st International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation, Inc, 222 E Redwood St, Baltimore, Md, 21202.

6th Annual Meeting of the Association of Labor-Management Administrators, and Consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, Ariz, 85010.

Abroad

6th International Conference of the World Union of Organizations for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28 Place Saint-Georges, F-75442, Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic, Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Dilemmas in Treatment — July 24-29, 1977, Venice, Italy. Information: Clara Shapiro, conference coordinator, Center for Policy Research, 475 Riverside Drive, New York, New York, 10027.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28-Sept 1, 1977, Bergen, Norway. Information: Peter Nathan, department of Psychology, Rutgers University, New Brunswick, New Jersey.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Liberal drug laws won't do much

WASHINGTON — Any relaxation of some present hard laws on drugs in the United States would mean "you would not see a situation that would be terribly different from what you have right now," according to Peter Bourne.

Dr Bourne is special assistant to President Carter for mental health and drug abuse matters.

At the same time, said Dr Bourne, people must face up to reality "and say that we need to maintain a level of discouragement to using all drugs."

Marijuana should be kept illegal, but penalties for possession should be reduced.

"I think if you do that, it makes it that much easier than to try and deal with tobacco and alcohol in the same health context, because you can make the same arguments then much more legitimately about tobacco and alcohol than are now being made against heroin and other drugs."

Reducing penalties would mean that "people with a heroin problem, for instance, would be much more willing to come in and get treated if they felt it was not a reflection of a major criminal activity on their part." Trafficking and criminality would also be reduced.

He could see no merit in legalizing heroin, which is advocated by some black leaders, as it would remove any inhibition about or discouragement from its use.

"I think the black community would be worse off because there would be some legitimization to the pushing."

In the field of preventive education, Dr Bourne said "if it can work at all, it can only be done by dealing with kids at a young age. I think it can only be done successfully if you link together all substances of abuse and don't get into subtleties of legal distinctions.

"I think you have got to say to kids the physical and mental damage potential from these substances is true across the board, regardless of whether it is legal or illegal.

"In this way, heroin and cigarettes should be looked at on a par, from a health standpoint, even it they are not really."

Some programs can work: a number of people have described very young children coming home from school and making them feel embarrassed about smoking cigarettes. Value systems differ from region to region, and it is probably appropriate to have some things determined at the state level.

Dr Bourne, however, has a reservation. "This is to do with the fact that while I feel it is just a wonderful and fine idea, I just wonder how much it can work.

"We have put a lot of money and a lot of effort into prevention and everybody thinks prevention is really good. I have seen programs where I think it has probably been effective, but I have yet to see a program where there is dramatic demonstration that it was effective.

"That is one of my concerns."

On the rising rate of alcohol abuse by young people, Dr Bourne said: "To some extent you are going to have to live with it.

"I think if you have a global anti-substance abuse education program you, hopefully, can convince young people the excessive use of alcohol is just as damaging as the excessive use of heroin, or anything else.

"Again, I am not sure that our programs have been that effective in convincing young people that that is the case."

A major factor is growing teenage affluence and this, in turn, leads to greater access to alcohol.

"It is built into our culture as almost part of adolescent life to use alcohol to excess. To really reduce the use in this country you have got to change the value systems that relate to alcohol."

Temperance
A faint echo still sounds

By Clarie Martin

"Come and join the temp'rance army and fight against saloons,
Shouting the battle cry of temp'rance;
We will fight the mighty evil that's ruining our homes,
Shouting the battle cry of temp'rance.

Chorus:
"Yes, once and forever, the grog shop must go;
Down with the brewery and shut off the flow;
And we'll rally 'round our standards and go for the saloon,
Shouting the battle cry of temp'rance."

TORONTO — The inebriate, who cares to listen, need fear much less today the loss of his bottle through force, legislation, and sermonizing for what remains are echoes of the battle cry of temperance.

Like champagne that fizzes mightily then settles down, the strong temperance movement which made a historic impact on society in the last half of the 19th century and the early decades of this one, stomping the 'Demon Rum' and establishing prohibition, has dwindled to a comparable handful of followers in Canada. Those groups which remain true to the temperance cause are not as strong as in earlier years and some teeter on the brink of extinction.

Other Canadian organizations concerned with the use and misuse of alcohol and drugs have put aside the temperance philosophy of total abstinence — for the time being at last — in favor of education.

And even some churches are less stringent about the use of intoxicants among both laity and clergy.

The meaning of the word 'temperance' is somewhat paradoxical. On the one hand it means moderation, self-restraint, and self-control in action, conduct, speech, and especially eating and drinking, particularly alcohol. On the other, probably due to the formation of the temperance movement itself, the word has come to mean total abstinence from intoxicants.

Fern Barnes, national president of the Canadian Woman's Christian Temperance Union explained: "As far as total abstainers are concerned, we believe temperance means moderation in all things wholesome, and total abstinence from all things harmful."

The WCTU is probably the largest and most effective temperance organization in Canada today although Mrs Barnes said she is unable to say how many members it has overall. The WCTU, founded in Cleveland, Ohio and first organized in Canada at Owen Sound, Ontario in 1874, has active locals in every province except Quebec.

Mrs Barnes claimed the membership of the WCTU is growing though not rapidly. "Today, women are working so much they just can't take on too many organizations although they are *with* us and lots of them support us financially."

A woman who signs the pledge of the WCTU receives its magazine, *The Canadian White Ribbon Tidings*, five times a year and becomes involved in the WCTU philosophy, which Mrs Barnes said is "education, legislation, and agitation."

One of the oldest temperance groups in Canada is the Order of the Sons of Temperance, established in New Brunswick, Nova Scotia and Lower Canada in 1847 and in Upper Canada a year later. National President Annie Lytle said its membership has declined rapidly in recent years.

Today, the Sons of Temperance has small lodges in Nova Scotia, New Brunswick and Prince Edward Island. When staunch and steady older members die no younger people take up the cause, said Mrs Lytle, adding that the modern philosophy of moderation has not helped the membership much either.

"People want moderation and we're strong against any drinking at all."

The Independent Order of Good Templars established lodges in British North America in the early 1850's and, in 1854, organized its Grand Lodge to direct about 56 local lodges in Upper Canada. Within five years this Grand Lodge had grown to include 350 lodges with a total membership of almost 20,000, with similar growth in other provinces.

19th century crusade against intemperance — pleading with a saloon keeper.

About 62 members keep the Independent Order of Good Templars alive in Canada today, according to Georgia Farrow, president of the Grand Lodge of Nova Scotia, because "nobody wants to be temperate".

With such a small membership, funds are difficult to raise, said Mrs Farrow, and without funds the Order isn't able to do much to combat the use of alcohol.

David Reeve, executive director of Alcohol and Drug Concerns, Inc, a non-profit registered Canadian charity with headquarters in Ontario, suggested one reason for the lack of popularity of the temperance movement today and its downward trend.

He blamed a widely fostered image of the spoil-sport, anti-social "temperance crank" which, he said, was blown out of proportion to its reality by those who found it profitable to foster the negative aspect of abstinence.

Words like "abstainer", "teetotal" and "temperance" have taken a beating in the eyes of the public, he said, and, therein, lies part of the reason for the dissolution of the Ontario Temperance Federation in the late sixties.

"By 1966, with the coming of the drug culture, the Ontario Temperance Federation was really having great difficulty in maintaining its credibility," said Mr Reeve. "It had taken very strong stands in terms of local option votes and issues with government that had to do with increasing permissiveness of the sale and advertising of beverage alcohol.

"Our organization was reincorporated in 1968. We see ourselves as an organization of citizens that speaks of alcohol and drug issues today rather than being a link with the classic temperance movement."

The aim of Alcohol and Drug Concerns is to "encourage and promote a lifestyle that is independent of alcohol and other harmful drugs." That is an "entirely new language" that allows both temperance and moderation, said Mr Reeve, and emphasizes such words as "awareness" and "concern".

Avoiding temperance philosophy and policy and condemned words that reek of teetotalism are other organizations involved in alcohol and drug problems.

The Nova Scotia Federation on Alcohol and Other Drug Problems stands behind a total sobriety movement.

Said its executive director, Robert Upton Day, "We want people to regard alcohol as something that has to be used in a disciplined manner and not to excess."

Mr Day explained he is involved in educating people about the hazards of the excessive use of all mood-modifying drugs, but his movement is not as severe as that of the Sons of Temperance and the Woman's Christian Temperance Union. "We're temperance but not the total abstinence view that they uphold."

The Alcohol, Drug Education Services (ADES) of Manitoba and British Columbia are into similar educational programs, providing scientific facts and allowing individuals to decide for themselves whether they will use alcohol and other drugs.

Stanley Steinmann, associate executive director of ADES in Winnipeg, emphasized that ADES' policy is to "give kids facts about alcohol and drugs and encourage them to realize that there is a way of life that can be happy and successful without the use of these things."

He said: "There are so many facets of approach that it would be self-defeating to say this (total abstinence) is the only way. It would turn a lot of people off and we need the support of the general public."

However, he added: "Our underlying thrust right along is to have people see that perhaps temperance is the thing."

In Vancouver, Frank Dignman, executive director of ADES, said it is an "information-giving agency".

"I'm not saying prohibition is not a good thing," he said. "It's not our policy now. We're trying to get facts before people so they can make wise judgments about how they use a very dangerous drug."

One direct outcome of the temperance movement in Canada is the Abstainers' Insurance Company of Ontario and Alberta which underwrote $7,720,000 premiums last year.

Arthur Blair, president and managing director, said the company began by selling just car insurance to people who abstain totally from alcohol but in 1967 expanded into personal property insurance.

"Most abstainers are also non-smokers and about 30% of all fire claims where cause is known are the result of careless smoking and use of matches."

Mr Blair said the cost of car insurance for an abstainer can be as much as 20% below the official public statistics.

"Fifty percent of car accidents involve a drinking driver. If that is true we ought to be able to insure those people who don't drink for less money and still make money. The experiences of 20 years have established that."

He added: "The very fact of our existence as an abstainer insurance company that has grown and prospered supports the temperance movement."

Dr John Linton was for many years secretary of the now defunct Canadian Temperance Federation and has spent a major part of his life working in the field of alcohol problems.

He said: "Some of the (temperance) organizations were particularly oriented in the Church. The Church was the strength of the temperance movement but it wanted to add to its strength by accepting those who drink moderately."

Many people within Baptist, Presbyterian, Pentecostal, Nazarene, Free Methodist, and other such groups still follow a tradition or policy of abstinence as do Mormons, Seventh Day Adventists, people of the Christian Science Churches and those of the Bahai faith.

Captain Orville Cole of the Salvation Army stated: "In order to be a member of the Salvation Army you have to promise total abstinence from tobacco and alcohol. Our stand is absolute."

Rev. Bob Lindsey, associate secretary of the Division of Mission of the United Church of Canada, said: "Total abstinence is not the core of Christian testimony but it is related. An awful lot of United Church people and clergy take a drink. But there is a sizable portion of laity and clergy who don't."

If living proof is required of the advantages of being temperate, perhaps Isabelle Perigoe of Mississauga, Ontario is it. She is 97-years-old, has been a teetotaler all her life, suffers no rheumatism, arthritis, heart problems or other maladies and joined the Woman's Christian Temperance Union in 1897 when just a schoolgirl in Halton, Ontario.

Last year she was honored as President Emeritus of the WCTU. She said, in explanation of her role in the temperance movement: "There has got to be something created within people to be their brother's keeper, to help somebody else."

Explaining her long life, Mrs Perigoe quipped: "I've been temperate in all things."

In her time, Nellie McClung (left) commanded fees of up to $200 a week to speak at temperance gatherings on the Canadian prairies. Isabelle Perigoe, 97-year-old President Emeritus of the WCTU, has tried to be her "brother's keeper since 1897."

THE BACK PAGE

PTU—new hope for alcoholics and taxpayers

By John Shaughnessy

TORONTO — An anti-thyroid drug offers new hope to alcoholics suffering severe liver disease.

A short term elinical study here indicates treatment with propylthiouracil (PTU) induces a more profound recovery from liver abnormalities in these patients and in a shorter period of time than that experienced by placebo-treated patients.

The clinical study of PTU was prompted by experiments conducted at the Addiction Research Foundation of Ontario and the University of Toronto two years ago. Those experiments showed the drug protects rats consuming ethanol against hepatocellular damage produced by hypoxia.

Harold Kalant, who headed the research teams involved in both the clinical and earlier animal trials, has repeatedly stressed the importance of the work. Recently he said if this treatment is successful in shortening by 50% the average hospital stay of patients with cirrhosis, the economic saving would in a few years repay the entire cost of alcoholism research in Ontario up to the present time.

In the recent clinical trial, the beneficial effect of PTU was observed both in patients with alcoholic hepatitis and in

(See — PTU — page 5)

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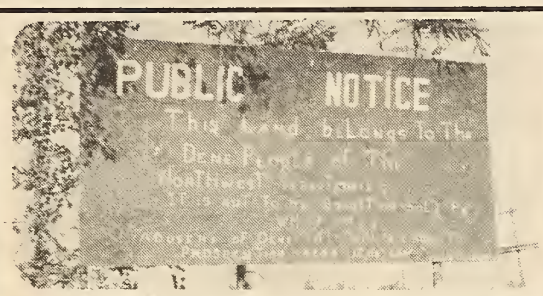


They're choosing their own way

For the first time, settlements of Indians and Eskimos in the vast Northwest Territories of Canada may set their own liquor policies. Prohibition is spreading like a bush fire, Nancy Cooper writes from Yellowknife. See The Back Page.

President moving on pot, coke

WASHINGTON — Removal of criminal penalties for possession of marijuana is being sought from the American Congress by President Jimmy Carter.

In addition, his administration is examining its position on cocaine possession.

Peter Bourne, whom Mr Carter selected to head the Office of Drug Abuse Policy, told a Congressional committee the Carter administration "will continue to discourage marijuana use, but we feel criminal penalties that brand otherwise law abiding people for life are neither an effective nor an appropriate deterrent."

As for cocaine "this is an extremely complicated issue and we are in the process now of carefully reexamining our position," Dr Bourne added.

Canada takes lead in UN debate

By Anne MacLennan

GENEVA — Canada has received strong support "at the bar of world opinion" in its protest against a US proposal to grow scarlet poppy for up to 20% of its own codeine supplies.

And it is now likely President Jimmy Carter himself may have to make the final decision on whether the US will go ahead with commercial cultivation of the poppy, *Papaver bracteatum*, Mathea Falco told **The Journal**.

Ms Falco, formerly legal counsel with the Drug Abuse Council, was recently appointed senior adviser to the US secretary of state and co-ordinator for international narcotics matters, and headed the US delegation to the February meeting in Geneva of the United Nations Commission on Narcotic Drugs.

Speaking before the commission, after a debate on licit opiates which was sparked by Canada and stretched over two days, Ms Falco said the US proposal would be "carefully weighed in the light of many factors, both domestic and international.

"I have listened and will continue to listen with great attention to the remarks of the speakers ... I am carefully noting their views in detail.

"I can assure them personally, I will communicate these views to all of the US authorities involved in considering this complex issue. The views of their governments will be given the most careful attention."

Canada's position, which is now shared by many other countries, is that US cultivation of the poppy for codeine would upset the delicate international balance that now exists between supply and demand for licit opiates.

The effects would be particularly severe, Canada believes, in countries such as Turkey, which

(See — Nations — page 5)

Don Smith, (left) head of Canada's delegation to the UN Commission on Narcotic Drugs; with him is Dr T. R. McKim, also a Canadian representative at the meeting held in Geneva in February.

International drug problem

Deterioration may set in

GENEVA — The international nature of the drug problem is more widely recognized than it has ever been and this should make the continuing fight against drug abuse more effective.

However, danger still exists that the situation may deteriorate and require more intensive and more expensive counter-measures, according to the International Narcotics Control Board.

In a report to the United Nations Commission on Narcotic Drugs, Professor Paul Reuter, president of the INCB, said the fight against drug abuse throughout the world has made progress in recent years largely as a result of the two latest international drug treaties — the 1972 Protocol amending the single Convention on Narcotic Drugs, 1961, and the 1971 Convention on Psychotropic Substances.

Bilateral relations between states on matters of drug control have also been extended; regional cooperation has increased; and technical and financial assistance has been furnished to a growing number of countries.

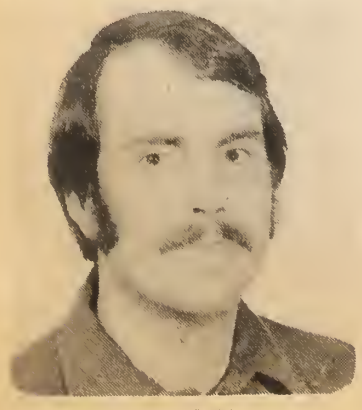
However, said Dr Reuter, there are three aspects to the drug problem: illicit supply, illicit demand, and the traffic which links this supply with demand.

(See — Drug — page 5)

Draft lists 400 alcohol agencies in Canada

By Manfred Jager

WINNIPEG — A draft listing every alcoholism treatment and rehabilitation service now operating in Canada has been completed by an assistant professor in the department of social and preventive medicine of the University of Manitoba.



Angus Reid

The document contains listings of about 400 service agencies, which were researched last summer as to their history, funding, type of work, and clientele.

Angus Reid, author of the report, told **The Journal** it is the forerunner of a comprehensive analysis of alcoholism and drug dependence services in the country, expected a year from now.

The project is financed through a $120,000 federal health department grant covering the years 1975 through March of next year. Dr Reid employed a dozen research assistants for data gathering on a full-time basis last year.

He said one of the first interpretive facts to come out of the compendium is that the average age of alcoholics in Canada is on the way down.

"We can no longer confine ourselves to talking about the problem drinker as a person in his or her late 50s or early 60s," Dr Reid said. "We have agencies which report the age span of their clients starting at 15 and reaching all the way up to 70, giving an average age of 26."

The sociologist said the interest and concern was "at a pragmatic policy level to come up with a review of the state of the art in this field, which has gone from nothing in 1950, to virtually a $100-million-a-year industry — from a couple of agencies to well in excess of 400 a mere 25 years later, employing well over 3,000 people across the country."

While the $100 million is public money, the amount compares relatively insignificantly to the $1 billion federal and provincial governments take from the public in profits and taxes through the sale of liquor.

"At the very minimum we want to find out what exactly is out there in the field and how services are developing and changing to meet the need in the most effective manner."

Dr Reid said the analysis phase of his project will indicate what approaches to alcoholism and drug abuse are the most effective in various areas of Canada. Approaches differ because addic-

(See — Final — page 6)

Regular features

There's an important 'fifth factor' in drug war

By Anne MacLennan

GENEVA — There's an insidious "fifth element" in the international fight against drug abuse that isn't often publicly discussed and is sometimes not even acknowledged.

It's official corruption and in some countries it's as visible as enforcement efforts are, if not more so. Some places are trying to deal with it.

At the meeting in Geneva of the United Nations Commission on Narcotic Drugs, official corruption, as a problem, got slightly more than passing reference from Peter Lee of the Hong Kong — United Kingdom delegation.

Mr Lee listed the four main elements in efforts to combat narcotics abuse — law enforcement, treatment and rehabilitation, preventive education and publicity; and international cooperation.

And in Hong Kong, there has been "an increasing coordination between these four main elements of our efforts to combat and reduce this pernicious social evil," he said.

"There is, however, a fifth element which has had considerable influence in stimulating and continuing the illicit trade in narcotic drugs in Hong Kong.

"This fifth element is official corruption. With an annual expenditure by drug abusers in Hong Kong, estimated, very conservatively, at $120 million, the profits to be made from this vile business are enormous, and afford ample opportunity for securing cover and protection.

"Recognizing that corruption feeds on evils such as drug addiction, prostitution, and gambling, as flies feed on cesspits, the Hong Kong government set up an independent commission against corruption three-and-a-half years ago, supported by a new Bribery Ordinance conferring new and considerable powers of investigation and control.

"Since then, the commission has had an increasing impact in seeking out and bringing to justice those who demean our laws, and abuse their official positions.

"We believe that this unremitting effort will continue to have an important effect on our overall anti-narcotics struggle, in addition to the four major elements I have previously mentioned."

With law enforcement action resulting in curtailment of drug supplies, and rapidly increasing overheads expended by drug traffickers on security, the prices of illicit drugs in Hong Kong are steadily being pushed up, said Mr Lee.

In August, 1976, the illicit wholesale price of No. 3 heroin climbed to an all-time high of about $11,000 a kilogram — four times the price it was two years ago and double the price at the beginning of the year.

Mr Lee noted that seizures of opium and morphine in 1976 were "well in excess of those made in 1975, and amounted to 3,550 kg of opium and 230 kg of crude morphine." He said 11 clandestine heroin laboratories were detected and destroyed; some 3,200 prosecutions for trafficking/manufacturing were undertaken during the year; and 10,000 prosecutions were made for other drug offences such as possession and smoking.

Hong Kong grows no opium poppies and illicit drugs arrive from the Golden Triangle, via Thailand.

"The fragmentation of major drug syndicates that resulted from enforcement operations in 1973/74 was maintained in 1976 and the majority of the former high echelon drug personalities who evaded arrest two years ago have either remained in hiding or have moved overseas."

In mid-1976, there were signs indicating a return to the traditional method of importing bulk consignments of drugs into Hong Kong using Thai fishing trawlers and Hong Kong based junks.

An "interesting feature" in 1976, according to Mr Lee, was the diversification in the types of drug imported. In the past, imports were mainly limited to raw opium and morphine. Recently, there's been a significant incidence of imports of prepared opium and heroin. These drugs need no further refining or preparation once they reach Hong Kong and the risk of detection at that stage is thereby removed.

"Thai heroin was at one time not favored by Hong Kong addicts who claimed that it had a bitter taste and was unpleasant to consume. The migration of Hong Kong chemists to Thailand, and the adoption of revised manufacturing techniques by Thai chemists, has overcome this problem and high grade Thai No.3 heroin (of up to 40% purity) has featured increasingly in seizures during recent months."

Dr George Ling, UN drug director

Demand reduction moves into focus

GENEVA — Reduction in demand for both licit and illicit drugs is finally getting some equal time with supply reduction at the international level.

This was one of George Ling's main impressions of the February meeting of the United Nations Commission on Narcotic Drugs. Dr Ling is director of the UN's Division of Narcotic Drugs.

He told **The Journal**: "There is increased awareness now of the role which effective demand reduction can play in reducing drug abuse. Previously, we always thought supply reduction was good.

"Experience has demonstrated this is not entirely correct. In the last several years, increasing interest has been expressed in demand reduction. We're trying to reduce personal interest in drugs and personal demands which individuals have for using drugs.

"You can have a cupboard full of alcohol but if no one is interested, no one will touch it."

The commission has recognized the need for more emphasis on demand reduction, he said, and, under him, the division will be studying "all possible measures which can be used to reduce demand for both illicit and licit drugs. They have made it clear there should be a balance between demand reduction and supply reduction.

"The two go hand in hand."

Referring to the 1971 Convention on Psychotropic Substances, which entered into force on Aug 16, 1976, Dr Ling said there has been "expressed willingness by all members (of the commission) to implement this convention as soon as possible."

It will assist developing countries to reduce the increase in non-medical use of psychotropic substances with its consequent hazards to individuals, he said.

"There is increasing evidence that there is an emerging consistent pattern of multiple drug abuse in developing countries including primarily psychotropic and synthetic psychotropics (morphine and opium) and, still more recently, alcohol, although the commission doesn't deal with alcohol.

"Implementation of the convention will permit a mechanism at international level where licit drugs can be controlled at all levels, starting with governments, with customs, the whole distribution system."

Until the new convention entered into force, only narcotic drugs were under international control. The 1971 convention bring substances such as hallucinogens (LSD, Mescaline etc), stimulants, and sedative hypnotics also under that control.

Officials of the United Nations at the meeting of the Commission on Narcotic Drugs. Dr Ling, director of the Division of Narcotic Drugs, is third from the left. Meeting took place in Geneva in February.

LA drunk drivers facing 48 hours in jail

LOS ANGELES — Stricter penalties for drunken driving have been approved by a city council committee as part of a seven-point program to combat drunken driving.

The program advocates:

- A minimum sentence of 48 hours in jail for the first offence and longer sentences for repeaters.
- An increase in the maximum fine from $500 to $1,000.
- A 0.1 blood alcohol reading as sufficient proof of drunkenness.
- Expansion of the court's power to limit driving privileges.
- All offenders must attend alcohol and other drug programs.
- Defendants in drunken driving cases must appear in court.

The recommendation of a 0.1 blood alcohol level as proof of drunkenness is also under consideration by the State Legislature.

Under present California law when a test of blood, urine, or breath shows an alcohol level of 0.1 or more it is a "rebuttable presumption" of drunk driving.

A bill proposed by Democratic Senator Arlen Gregorio would make it unlawful for anyone to drive with 0.1 blood alcohol, with no rebuttal allowed.

Better you should be corrupt than smoke pot

By Wayne Howell

WHEN IT comes right down to it, there is probably no better place to smoke marijuana in Canada than on Parliament Hill. The Hill has traditionally been exempt from the petty laws that govern behavior in other parts of the country.

The Liquor Control Board of Ontario, for instance, has never had the temerity to shut down the press gallery Blind Pig that has provided liquid refreshment to a generation of politicians because it does not conform to Ontario law re the merchandising of alcoholic beverages.

As long as Bill S-19, the bill removing marijuana offences from the Criminal Code, remains moribund (technically it expired on the order paper during the last session of parliament although there is talk of reviving it) anyone apprehended for smoking marijuana in any less hallowed halls of the dominion can get stuck with a criminal record, and if he comes up against a hanging judge (i.e. one with a nasty hangover) he can actually go to jail.

Meanwhile . . . back on the Hill, December 22, 1976. The traditional end of session party in the Speaker's Chambers. A joint went 'round. And within days the news (of a sort) was seeping out.

The incident was first recounted by Marjorie Nichols, parliamentary correspondent for the *Vancouver Sun*, who breathlessly informed Barbara Frum, Canada's gossip columnist of the airwaves, that several backbenchers had partaken of the burning offering, which originated among members of the fourth estate; one cabinet member had recoiled in horror (he was named) and another cabinet member had taken a drag (this one un-named, but identified as to sex). *The Globe and Mail*, Canada's "national" newspaper, picked up the story the next day, but added no details. Significantly, the Canadian Press did not move the story on its national wire. And so the story fizzled out.

To this day, no member of the working press has divulged the name of the cabinet member who took the toke. Now this is curious because The Press — both Canadian and American — has not been reticent in recent years about divulging other information about politicians that is potentially quite damaging: a Canadian cabinet minister was once identified as having had an indiscreet liaison with a Mata Hari type femme fatale; members of parliament have been identified as being associated with financial dealings of a most suspicious sort; and members of parliament have been identified — by name — as being drunk in the House of Commons. It is not incidental that these MPs still hold their seats in the House of Commons.

Extramarital sex, questionable business dealings, and booze, the public can excuse. As a matter of fact, the public's tolerance in this regard is remarkably high. Wilbur Mills, the Chairman of the American Congressional House Ways and Means Committee did not lose his job because of his liaison with a stripper; he only lost his job when he went so far as to appear on stage with her in Boston while she was doing her number. And the Canadian cabinet minister who took his mistress on a well publicized (courtesy of the press) Air Canada junket is in no danger of losing his seat. But marijuana? That is obviously something else.

There appears to be a consensus in the Press Gallery that if an MP were identified as having smoked marijuana, he (or she) would suffer a grievious blow, i.e. it is something one could easily lose one's seat over. Especially if one were a cabinet minister. No member of the press wants to take that responsibility upon his (or her) shoulders and consequently the name of the cabinet minister who partook of the burning offerings will be forever beyond the public's grasp.

It appears that marijuana — even in the age of Bill S-19 — is still the last taboo.

(Wayne Howell is an Ottawa physician and freelance writer).

Lawyer Ragnar Tomasson of Iceland (left) confers with James Rankin of the Addiction Research Foundation of Ontario. Mr Tomasson is studying the possible effect of the introduction of 'strong beer' to his country. Some Icelanders see beer as a curb on consumption of alcohol.

Icelanders are all stirred up by 'strong beer' proposals

By John Shaughnessy

TORONTO — Can beer reduce a country's problems with alcohol? That's the question now facing Iceland's 220,000 citizens.

One member of the Althing, Iceland's Parliament, has proposed that "strong beer", which is now illegal, be permitted on the island. Since the proposal, the issue has become the most important thing in the lives of Icelanders, says Ragnar Tomasson.

Mr Tomasson, a Reykjavik lawyer and volunteer worker with young people's abstinence groups in the country, recently visited the Addiction Research Foundation in Toronto to gather information on the effects of beer on overall alcohol consumption data.

In an interview with **The Journal**, he said under existing Icelandic law, the minimum drinking age is 20 and only distilled spirits are sold from government liquor outlets or are available with meals in restaurants. A "light beer" is available but "it's impossible to get drunk on it."

Despite this, the annual consumption of alcohol in Iceland is about 2.85 litres per capita, and the feeling in the country is that drinkers get drunk — that you see more drunks on the streets of Iceland than you do in countries with higher per capita consumptions of alcohol.

Those favoring the introduction of beer see it as a way of reducing drunkenness and other problems associated with alcohol. The reasoning, according to Mr Tomasson, is that Icelanders like a glass in their hands when they're having a chat with friends.

If only distilled spirits are legal, they get drunk, but if they could drink beer this would be less likely to occur. In effect, the proponents of introducing beer think it will replace, or be an acceptable alternative to, hard liquor with a consequent reduction in alcohol problems.

Opponents of the proposal cite experiences in countries such as Sweden and Finland which indicate the introduction of beer won't replace the drinking of hard liquor, but will only be an addition to it. They also fear if beer is introduced, drinking by young people will increase, and workers will drink while on the job.

On this point, Mr Tomasson said Icelandic seamen have been returning home with stories of how work crews in such places as Copenhagen have one member whose sole job responsibility is to keep the crew supplied with beer throughout the work day.

Mr Tomasson said the rhetoric on the issue in Iceland is equalled only by the lack of information on the consequences of introducing beer to the country. His trip to Toronto was to get such "scientific information".

"It would be a sad thing to introduce beer to Iceland in hopes of improving the situation, and then discover that the problem's getting worse," he said.

"Once beer is allowed it would be impossible to get rid of it. We shouldn't take the risk until we have evidence that beer will reduce our problems, and so far it seems that the evidence is all the other way."

Mr Tomasson also said those arguing for the introduction of beer take a "liberal" stance and suggest common sense and education programs are better than legal prohibitions. "But information available from the ARF and other centres shows education alone doesn't prevent people from doing what they want to do.

"In Iceland, the first people to misuse drugs were doctors and nurses — people you would expect to be most educated about the hazards."

Mr Tomasson personally feels the proposal to introduce beer will not succeed, but at the present time the issue "is too sensitive for the politicians even to talk." There is the possibility the proposal could be buried in committee, but he thinks public interest is too high for that to happen.

"Right now," he said, "people are taking stands without asking questions, and without expressing any doubts. It's an emotional issue, but the number of drunks on the street doesn't tell us much about alcohol problems in general. I'm hoping to bring back solid information for the few people who do think before it comes to a vote."

ADPA re-embraces CSTAA

States return to the fold...

WASHINGTON — The Council of State and Territorial Alcoholism Authorities, after three years as a separate entity, is returning to the umbrella of the Alcohol and Drug Problems Association of North America.

The merger, which becomes effective later in the year, means also restructuring of the ADPA.

Under the plan, three councils will make up the ADPA organization. These will represent state directors, agencies, and individuals.

Each council will elect its own board and set its own objectives. An integrated ADPA staff will be responsible for implementation.

Each council will elect three members to the full ADPA board and an additional six board members will be chosen from the membership at large.

Thomas Price, PhD, who has been director of CSTAA since its founding in 1974, says: "The objective is to get a broader constituency base than just the state authorities, and to strengthen the ties of the state agencies to the local service providers.

"When you look at it, the states are related to all of these organizations in one way or another, and it didn't make sense to the states in the first place to have CSTAA as a separate organization."

It was at the insistence of the National Institute on Alcohol Abuse and Alcoholism that the states split off from ADPA.

Dr Price adds that the states will "now be integrated into the full range of alcoholism and drug abuse services and through the ADPA there will be unified representation as far as Congress is concerned."

When the merger is complete, Dr Price will step down. He explains: "I came to make a contribution, not a career. I have made that contribution and I am ready to go on someplace else."

Augustus Hewlett will continue in his role as executive director of ADPA.

Mr Hewlett says: "Naturally I feel very good that the states in terms of the public image will be reidentified with the group they started back in 1949.

"I think the reorganization is going to be much more attractive to the other two categories of membership. It gives them the same degree of autonomy, it allows them to elect their own boards and to have input into the organization as a whole.

"The ADPA board will be more one of coordination, liaison, and direction, rather than policy setting. However, this does not mean it would not set some policy at times."

. . . And want feds to merge

WASHINGTON — A majority of state alcohol and drug agencies have expressed a preference for a proposed merger of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

The state agencies were polled by the National Association of State Drug Abuse Program Coordinators and the Council of State and Territorial Alcoholism Authorities at the request of senators considering a bill to merge the two federal agencies.

There were no surprises in the states where the agencies are already combined: none opposed the proposal. However, in states where the agencies are separate, a majority either favored the merger or took no position.

It discourages use of alcohol, pot

NORML Canada aims to be politically palatable

By Tim Padmore

VANCOUVER — NORML Canada, a new society set up to lobby for the decriminalization of marijuana laws, is, officially at least, against the use of marijuana.

An official policy statement adopted in February states:

"NORML Canada fully supports a discouragement policy towards the recreational use of all drugs, including alcohol, tobacco, and marijuana."

The statement reflects not so much concern about the hazards of marijuana use but the realization that if the society expects to influence government policy, it will have to make its ideas as politically palatable as possible.

'We want to alienate as few people as we can.'

"We want to alienate as few people as we can," said NORML director Edward Siefred in an interview with **The Journal.**

As far as safety goes, Mr Siefred believes marijuana to be one of the best-studied and safest drugs in existence.

Evidence indicating marijuana causes chromosome damage, interferes with immunity, and causes a so-called amotivational syndrome is flawed, he says.

He cites particularly the Jamaican study of heavy marijuana smokers which found no evidence of amotivational syndrome or physical ill effects, such as increased susceptability to disease.

It seems, Mr Siefred says, that the government is ignoring the evidence.

"It's five years since LeDain came out advocating decriminalization of the possession of marijuana. Like most Canadians, I sat back and waited for the government to act, but now it's clear they're not going to act without some pressure."

He says that as a criminal lawyer he is upset by the impact of present laws on people who are in no way criminal, except for their use of marijuana.

'Two million Canadians, including 43% of all college students, have smoked marijuana.'

"They have good jobs, no criminal record, but they are being criminalized. And as a result they are having trouble with their jobs and are going to jail."

Two million Canadians, including 43% of all college students, have smoked marijuana, he said.

So far, the main manifestation of NORML Canada — the name is borrowed from the United States National Organization for the Reform of Marijuana laws — is a storefront office at 111 E. Broadway in Vancouver. It serves as headquarters for distributing pro-pot literature and signing up members.

Toronto lawyer Clayton Ruby, another of the organization directors, is trying to establish an office in Toronto, and more will be set up if the membership drive is successful enough.

The first lobbying effort is underway: a mailing to members of parliament of summaries of the latest marijuana research.

Mr Siefred says NORML Canada is using the expertise and advice of its US namesake, which has pledged cooperation, but is setting its own policy.

This main points of that policy are:

- The removal of all criminal and civil penalties for private possession of marijuana for personal use;
- The right to grow small quantities of marijuana for personal use;
- The right to transfer small quantities between adults for "insignificant consideration."
- Discouraging marijuana use through educational campaigns;
- Appointment of a commission to study systems for legal distribution of marijuana;
- No distinction between marijuana varieties of different potency;
- Prohibition of driving while under the influence of marijuana.

'It is both inconsistent and irrational to provide harsh and costly penalties for those who distribute marijuana for profit.'

The policy statement skirts the question of removing penalties for pushing pot, saying only:

"It must be recognized that where personal use and possession of marijuana are no longer serious crimes, it is both inconsistent and irrational to provide harsh and costly penalties for those who distribute marijuana for profit."

Mr Siefred says he hopes NORML Canada can duplicate the success of its American partner: decriminalizing marijuana legislation has been passed in several states. Similar action has been taken in Italy, Sweden, Netherlands and Columbia.

Public clings to its beliefs in speedy hangover cures

Coffee's a favorite

WASHINGTON — Fifty-two per cent of Americans believe one can sober up just by drinking a cup of strong black coffee, according to a recent survey.

And 68% believe a cold shower will reverse the effects of alcohol, reports the National Highway Traffic Safety Administration (NHTSA).

The study also shows 70% believe a can of beer is less intoxicating than an average drink of liquor, while 80% believe sticking to one kind of alcohol is less intoxicating than mixing drinks.

Health Research Ontario 1977

John Shaughnessy reports from a meeting held at the Ontario Science Centre, Toronto, March 4-5.

Health objectives must be paramount: Schmidt

TORONTO — Future changes in alcohol control measures should aim at preventing further increases in the prevalence of alcohol problems, says Wolfgang Schmidt, associate director of research at the Addiction Research Foundation of Ontario.

"There should be a moratorium on further relaxation of alcohol control measures, and future proposals to change legislative or other provisions governing the marketing and distribution of alcoholic beverages should be tested against a health objective. The relevant question should become: are the proposed changes likely to contribute to higher consumption levels and therefore to an increase in health costs?"

Dr Schmidt also recommends a taxation policy be adopted which maintains a reasonably constant relationship between the price of alcohol and levels of disposable income.

He says the cost of beverage alcohol, relative to other consumer goods, has been permitted to decline from year to year in virtually every jurisdiction for which such information is available.

And he feels an education program is needed to increase public awareness of the personal hazards of heavy alcohol consumption, the economic and other consequences for society of high consumption levels, and the potential public health benefits of appropriate control measures.

Dr Schmidt admitted these proposals are modest since their implementation would, at best, prevent further increases in consumption. But he pointed out current forecasts indicate by 1984 Canadian adults will consume an average of 3.95 gallons of alcohol annually — a 73% increase over the 1972 level.

Dr Schmidt told the meeting a revival of interest in control policies as potentially important preventive measures has been prompted by recent upward trends in the prevalence of heavy alcohol use and by the recognition of the importance of overall alcohol use in the population in producing such trends.

"Controls tend to focus on the population at large rather than on individuals — a focus which is consistent with the finding that changes in the general consumption level have a bearing on the health of the people."

With respect to this latter finding, Dr Schmidt said there is now a vast amount of evidence which makes it increasingly clear the level of consumption in a population is an important determinant of the prevalence of users of hazardous amounts; the larger the amount of alcohol consumed by the population as a whole, the higher will be the number of heavy consumers.

Further, from a public health point of view, he noted the risks of physical disease resulting from heavy alcohol use is now known to rise significantly at levels of consumption much below those ordinarily associated with alcoholism.

"The alcoholics, as we know them from clinics, constitute only a minority among the drinkers who consume quantities that are liable to produce illness and early death."

Studies of alcohol consumption indicate in most industrialized countries, the average consumption has risen more than 40% during the period 1960 to 1973. In Ontario, per capita consumption of alcohol rose from 1.79 gallons of absolute alcohol in 1960 to 2.47 in 1974, an increase of 72%.

These increases invariably resulted in higher rates of excessive use and alcohol related problems, said Dr Schmidt.

Biological research is making inroads: Kalant

TORONTO — Significant advances are being made in the understanding of alcohol and drug dependence.

According to Harold Kalant, recent biological research in this field has led to important discoveries concerning the mechanisms of acute actions of drugs, mechanisms of reinforcement of drug taking, mechanisms of tolerance and physical dependency, and mechanisms of drug related diseases.

Dr Kalant, professor of pharmacology at the University of Toronto and associate director of the research division at the Addiction Research Foundation of Ontario, outlined some of the more important developments at the meeting.

With respect to acute actions of drugs, distribution studies have indicated there is nothing remarkably specific about the delivery of the various drugs to different parts of the brain. The drugs tend to go wherever the blood flow takes them. However, Dr Kalant said, the sites at which they are active in the brain, and the way in which they are active on the nerve cells at these sites, do show remarkable differences.

The depressant drugs, such as alcohol and barbiturates, have been found to dissolve preferentially in the membranes which make up the outer surface of every living cell. In brain cells they tend to swell the membrane and thus squeeze or constrict the channels through which sodium and potassium ions must move across the membrane in order to generate the characteristic electrical activities of the cell.

"This swelling of the membrane therefore slows down the ability of the nerve cell to respond to stimuli, and reduces almost all of the energy-producing processes which the cell draws upon to maintain its activities," said Dr Kalant.

In contrast, heroin and other opiate drugs react with a set of highly specific receptors found only in certain groups of cells surrounding the central cavities of the brain. Dr Kalant said these receptors are chemically specialized areas on the cell surface which fit the drug molecules as a lock fits a key, and which therefore can selectively bind the drug to the cell and initiate the drug's action.

The invention of a method for identifying these selective binding sites for opiate drugs has made it possible to identify the endorphins, a group of naturally occurring, small protein-like materials in the brain which are taken up at these same binding sites, and produce actions very similar to those of heroin and morphine.

"It is now believed endorphins play an important role in regulating our awareness of and response to pain, our mood, and our level of motivation for various kinds of purposeful behavior," said Dr Kalant. "Opiates seem to be merely external substitutes for the naturally occurring substances."

The actions of the stimulants and hallucinogens have been investigated mainly in relation to their effects on the release of various chemical transmitter substances which carry messages from one nerve or brain cell to the next. Norepinephrine and dopamine are the two main transmitter substances implicated in the action of these drugs.

Dr Kalant said norepinephrine appears to be involved mainly in such functions as maintaining wakefulness or arousal, stimulating physical activity, and control of body temperature. Dopamine is involved in the smooth control of muscular coordination, and even more importantly in certain "as yet ill-defined" processes underlying the perception and mental interpretation of visual, auditory, and other sensory information reaching the brain from the outer environment.

Investigation has indicated the stimulant drugs displace the transmitter substances from their storage sites at the endings of the nerve cells, or prevent their reuptake into the nerve cells when their transmitter function has been carried out.

"The net effect of the drugs is thus to increase the amount of norepinephrine present at its point of action, and render the subjects more alert, active, and somewhat feverish," said Dr Kalant.

"Higher doses of stimulants, and especially of the hallucinogens, increase the output of dopamine in the same manner, and result in marked distortions of perception, which are recognized as hallucinations."

Turning to the mechanisms of reinforcement of drug taking, Dr Kalant said current research is directed towards identifying those parts of the brain in which the rewarding effects of the various drugs are produced, and the means by which they are produced.

"So far, no major discovery has been made in this area, but there is a high probability that the new work on the endorphins will soon permit identification of the site(s) at which the reinforcing effect of opiates is produced."

Attention is also being directed to the question of whether different drugs produce their reinforcing effects at different sites or whether they all act in their separate ways on a single reinforcing or reward system in the brain.

Dr Kalant predicted over the next two or three years much research will probably be aimed at exploring the effects of alcohol and other drugs of dependence on the formation and action of endorphins in the brain. "If endorphins prove to be a central link in the reinforcing system, they will offer a clear focus for efforts to reduce the reinforcing properties of drugs and thus to diminish the likelihood of dependence."

Dr Kalant said it is quite conceivable there might be innate differences in sensitivity to the reinforcing effects of alcohol and other drugs. A recent study in Denmark has rekindled interest in the genetic aspect of this problem, but Dr Kalant warned against jumping to simplistic conclusions. Heredity appeared to account for only about 25% to 30% of the probability of becoming alcoholic in the Danish study.

Recent research on the mechanisms of tolerance development has adopted a new strategy, said Dr Kalant. Instead of giving the drug in question until tolerance develops, and then looking for accompanying biochemical alterations, the tendency now is to produce a biochemical alteration by some other means first, and then see how this affects the ability of the brain to develop tolerance to the drug.

Some years ago it was reported that pCPA (pchlorophenylalanine) can deplete the brain of a transmitter substance known as serotonin. It was then found that animals which had been treated with pCPA did not become tolerant to morphine at the same rate as animals not receiving pCPA.

Dr Kalant said he and his coworkers have recently been able to confirm that pCPA has a similar effect on the development of tolerance to alcohol and to barbiturates. In contrast, when the animals are given large doses of a precursor which stimulates the formation of serotonin, they develop tolerance to alcohol and barbiturates more rapidly than the normal animal does.

"These findings suggest that certain circuits within the brain, in which serotonin is the transmitter substance, may be involved in regulating the rate at which the brain can become tolerant to a variety of different drugs."

Core shell treatment is tailor made: Glaser

TORONTO — A pilot project aimed at developing a planned and integrated treatment system for people dependent on psychoactive drugs is being conducted here by researchers at the Addiction Research Foundation of Ontario.

Rather than determining which treatment program is best for alcoholics or addicts, the core-shell project seeks to answer the more general question: "To what degree can a given citizen with problems related to psychoactive drugs achieve satisfactory results, given the sum total of resources which are systematically available to him?".

Frederick Glaser, project director, says from a public health viewpoint the latter question appears to be more crucial.

Dr Glaser said the core-shell system offers a fundamentally different approach to the treatment of psychoactive substance abuse. The rationale for the approach is based on four ideas:

- That people having difficulties in relation to psychoactive drugs are more different than they are alike;
- That, as a result of these differences, different clients may require different kinds of treatment;
- That current service delivery arrangements do not systematicaly take such differences into account; and therefore,
- That a treatment system which consistently takes client differences into account in differential treatment assignment should be designed and tested.

As described by Dr Glaser, the core-shell system will have as a major feature the provision of a "highly specialized and meticulous process of assessment" for each client which can, in turn, lead to an individualized treatment program uniquely suited to his needs and able to draw with equal facility upon all available treatment reosurces.

Dr Glaser emphasized that, under this system, not all clients would be provided with what are usually considered to be treatment services. "There is much to suggest that such an endeavor would be wasteful in the extreme," he said. "Many clients do not require these sorts of interventions, and many others cannot benefit from them.

Primary care, defined as the generalized function of case management and support required to varying degrees by all clients, will be provided to all. Secondary care, specialized intervention generally referred to as "treatment", will only be used if clear indications for its necessity are provided by assessment.

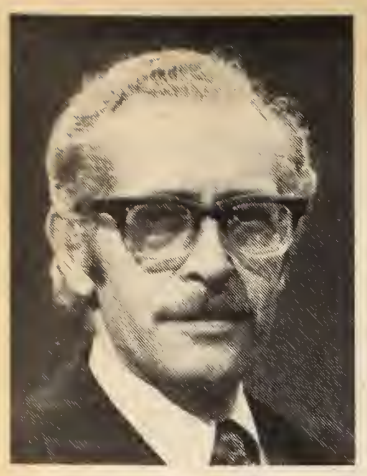
"In this manner, clients will not be given treatment services which they do not require or cannot utilize, while treating clinicians will be presented with a population of clients highly likely to respond to their ministrations," said Dr Glaser.

"The economies to be effected in terms of time, effort, expense, and in general of invaluable human and material resources, are expected to be considerable. At the same time, all clients are assured of receiving a basic level of service (primary care)."

Also, because the proposed system has a strong research component as part of its clinical operations, it will be constantly looking at the results it generates and, based upon these results, will readjust the patterns of assignment of clients to treatment interventions in order to produce an increasingly better match. Dr Glaser noted by this means the system should generate more and more positive results as it gains experience.

At present, the core-shell project is in the second phase of pilot development within the ARF's Clinical Institute. When this phase is completed, the experience and data collected will be carefully studied and a decision made regarding implementation. If this decision is favorable, Dr Glaser said, a full-scale trial of the core-shell system will get under way this summer, probably in July.

PTU is beneficial in severe liver disease



Harold Kalant

'It is still too early to predict the effect of PTU on the hospitalization of cirrhosis patients . . . but the results are promising.'

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patients with cirrhosis and alcoholic hepatitis.

But PTU favorably affected only those patients with the most serious abnormalities, said Hector Orrego, from the ARF's Clinical Institute and the department of pharmacology at the University of Toronto. It did not affect patients with only fatty liver or inactive cirrhosis.

Dr Orrego told the Clinical Research Society of Toronto here that the trial was randomized and double-blind, lasting a maximum of 45 days.

The study group consisted of 45 biopsied patients with cirrhosis, 18 with alcoholic hepatitis, and 22 with fatty liver. Forty patients had no biopsy. Sixty-one patients received PTU at a dose of 75 milligrams every six hours and 64 patients received placebo in an identical capsule.

A composite clinical and laboratory index was devised to score the severity of the patients' disease by weighing individual signs, symptoms, and test results on the basis of acceptable clinical experience found in a previous analysis of 85 patients with alcoholic liver disease.

"Although the scale is arbitrary, the high scores separate patients with cirrhosis from those with fatty liver," said Dr Orrego. "None of the patients with fatty liver had scores of more than six, while 46% of the patients with cirrhosis had scores higher than that."

He noted too that since cirrhosis and alcoholic hepatitis can exist asymptomatically, a low score did not exclude the possibility of cirrhosis and alcoholic hepatitis.

To show the effect of PTU treatment in changing the clinical and biochemical status of the patients, Dr Orrego and his coworkers analyzed the difference between the initial admittance and final discharge scores.

They found that in patients presenting with fatty liver PTU produced no statistically significant effect. But with alcoholic hepatitis the difference in the score from admission to discharge with PTU-treated patients was 4.1 compared to 2.4 with patients receiving placebo.

Analysis of a third group, which included only patients with scores of more than eight, showed that those receiving PTU had a difference of 5.8 from admission to discharge while the difference in those receiving placebo was 3.3.

Dr Orrego said since the time factor is of great importance in the assessment of treatment the research team devised a "normalization rate".

"The higher the normalization rate the more effective and faster were the results of treatment."

(The normalization rate represented the difference between the highest and lowest score in each patient divided by the number of days it took to reach the lowest score multiplied by 100.)

Measurement with this scale showed there was no difference between PTU and placebo in those patients with fatty liver. In patients with hepatitis with or without cirrhosis, the group treated with PTU had a normalization rate of 29.5 compared to 14.1 for the group receiving placebo.

In patients with cirrhosis without active hepatitis, Dr Orrego said, PTU had no significant effect compared to placebo treated patients. In contrast, patients with cirrhosis with active hepatitis who received PTU had a normalization rate of 32.4 while for the placebo-treated members of this group the normalization rate was 15.9.

Dr Orrego said side effects were noted in only four of the PTU-treated patients. Three developed a rash, and treatment had to be stopped. In the other patient there was "a rather marked" leukopenia, after 21 days of PTU treatment, but this patient returned to normal within two weeks of discontinuing treatment.

"The results of this study are encouraging," said Dr Orrego, "and they justify further testing of this drug in alcoholic liver disease."

These sentiments were echoed by Dr Kalant. In an interview with **The Journal,** he said it is still too early to predict the effect of PTU on the hospitalization of cirrhosis patients. "But the results are promising, and we hope they will persuade our ethics committee to let us use higher doses of PTU in our next trials. The PTU dosage used in this study was lower than that allowed for the treatment of hyperthyroidism."

Drug demand still raising problems

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"As regards supply, sources of supply have shifted rather than diminished.

"Moreover, demand is far from having decreased and it continues to raise numerous and complex problems.

"The board therefore appeals to governments not to relax their efforts and to continue to give priority to the prevention of abuse and to treatment programs, while at the same time continuing to curb illicit traffic.

"Otherwise, there is a danger that the situation may further deteriorate and require not only more intensive but also more expensive counter-measures."

The report notes that in the 20 years since the Commission on Narcotic Drugs first took note of the dangers arising from the abuse of amphetamines, a steadily increasing number of governments has become aware of the problems presented by the abuse of these drugs, as well as of hallucinogens, barbiturates, and tranquillizers.

"With the exception of hallucinogens, a large proportion of psychotropic substances which are abused come from licit sources," the report says. And it draws a parallel with the situation regarding opiates in the 1920s and 1930s.

Delegates to the United Nations Commission on Narcotic Drugs, held in February in Geneva at Palais des Nations.

International treaties are fragile structures

Nations must look beyond the purely economic

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are now authorized to produce opium poppy *(Papaver somniferum)* for medically required opiates, but would have a spillover effect in many others.

Don Smith, head of Canada's delegation to the commission meeting, and who led the debate on world supplies of licit opiates, explained to the commission: "Aware that perhaps no other concerned government could act in time, the Canadian government sent a diplomatic note on this subject to the US government on December 15." (**The Journal**, February)

". . . We have found by experience that it is best to make one's voice heard as soon as possible in these processes, expressing one's honest opinion and interest.

"Otherwise, one's point of view can be ignored, leading to misunderstandings afterwards," said ~~Dr~~ Smith, senior scientist, International Health Office, Health and Welfare, Canada.

Australia, Mexico, France, Thailand, the United Kingdom, and the Federal Republic of Germany, among other countries, supported the Canadian position. Yugoslavian and Italian delegations both noted particularly that in the United Nations, countries are morally, if not legally, obliged to refrain from acting out of purely commercial considerations.

The delegation from Turkey, which shifted from production of opium for the illicit market to production for the licit market under extreme pressure from the US, said:

"If this becomes a reality, the world prices will certainly fall and the economic interests of the traditionally and legally producing countries will consequently be affected . . .

"Furthermore, whereas the *Papaver somniferum* and opium are under treaty control, *Papaver bracteatum* is not itself covered by any treaty.

"To start cultivation of the raw material for the manufacture of opiates without taking into consideration the prevailing overproduction of the world, will certainly not be consistent with the spirit of existing international treaties.

Also, he said: "If the US will join the producer ranks, any action on the part of the US on narcotics control, will be construed as motivated by commercial considerations. I do not need to stress the negative effects such a feeling might have on international efforts in this respect.

"When a wealthy country is to resort to an action which can but be considered as being motivated purely by commercial considerations, the developing countries, with very limited resources, will have serious difficulties in justifying to their public opinion, the sacrifices they have been making from their economic interests in order to contribute to a humanitarian code."

'If bracteatum production were permitted it would take place in the strictest security conditions.'

Dr Smith, for Canada, added the humanitarian intentions of the commission's work "are perforce expressed through the international treaties.

"However, these are but the outward signs and effective only insofar as sovereign nations wish to apply them.

"The true authority of this commission is exercised through moral suasion at the bar of world opinion . . . Other factors do come in, but this fragile structure is based on something as tenuous as the recognition by nations that in this particular field, with its humanitarian implications, affecting as it does thousands, nay millions of victims around the world, countries must be seen to take a broader view than the purely economic.

"Otherwise, the whole international structure falls into disrepute and the world would be in for a chaotic situation, in the legal trade in opiates, with possibly disastrous consequences."

Speaking for the US, Ms Falco said the proposal to permit domestic cultivation of *bracteatum* (revealed in **The Journal**, January) was published in November, 1976 in the *US Federal Register* and "is a matter of public record.

"It is available to anyone who requests it."

She said the proposal responded to a petition made by several US pharmaceutical firms and representatives of the medical community, to the Drug Enforcement Administration, the US national drug control agency.

"The petition argued that limited domestic cultivation of *bracteatum* to supplement imported raw materials would secure for the United States some more stable supplies for the production of medically required opiates, as well as lower the cost of codeine."

Under the proposed regulations, production, in the first year, would be limited to 5% of US domestic requirements. In each succeeding year, this percentage would increase only slightly, reaching a maximum of 20% in five years.

"In addition, if *bracteatum* production is permitted, and I repeat that decision has not been made, it would take place in the strictest security controls to prevent any possible diversion within the United States or to neighboring countries."

Codeine, which accounts for 85% of world licit opiates consumption, is now processed from the opium poppy. The scarlet poppy, however, yields the substance thebaine from which codeine, in turn, may be processed.

Public hearings on the proposal were scheduled for mid-March in Washington.

Some members of the United States delegation to the UN Commission on Narcotic Drugs. Mathea Falco, head of the delegation is at the right. Peter Bourne is on her right.

California bill proposes legal pot cultivation

By David Milne

SAN FRANCISCO — A bill has been introduced in the California State Legislature that would eliminate arrests and jail sentences for people who grow small amounts of marijuana for personal use.

Under the new bill (AB 367) introduced by Assemblyman Willie Brown (Democrat-San Francisco), cultivation of six plants or less would be reduced to a misdemeanor punishable by a maximum fine of $100 without any jail sentence.

Enforcement would be through issuance of citations, rather than arrests, as possession of one ounce or less is now handled in California and several other states.

Cultivation of more than six plants for personal use would be considered a misdemeanor, punishable by a maximum fine of $500 and up to six months in jail.

Enforcement would be through a citaton or arrest, at the discretion of the police officer, as is the case with possession of more than one ounce of marijuana.

Cultivation of marijuana with intent to sell would remain a felony and would be treated the same as possession with intent to sell.

The new bill, says Mr Brown, would help to "take the profits out of the hands of drug dealers."

He reasons that treating possession and cultivation for personal use on an equal basis under the law will eliminate the incentive for purchasing marijuana from dealers.

A recent poll showed 35% of adults in California have tried marijuana and 14% or more than two million people consider themselves current users.

These two million subsidize an illicit marijuana market estimated at one billion dollars a year in California alone. And it costs California law agencies from $500,000 to one million dollars annually to prosecute those growing small amounts of pot.

Gordon Brownell, West Coast Coordinator of the National Organization for the Reform of Marijuana Laws (NORML), says the bill is both a logical and important step towards de-commercialization of marijuana in California.

The chances for its passage are good, says Mr Brownell, who considers a recent statement from the National Institute on Drug Abuse to be a major step to moving the bill along.

Robert DuPont, director of the NIDA, said removing criminal penalties for private cultivation of marijuana at home would correct an oddity that now exists in several states where possession of small amounts of marijuana is not a felony but growing or trafficking in it is.

"Personal cultivation in the home can be considered the functional equivalent of private use," Dr DuPont said in a speech to the Psychiatric Institute Foundation.

"Thus far, the trend has been to decriminalize possession of small amounts and sometimes 'casual' accommodation transfers between users," Dr DuPont said, "but no state has decriminalized cultivation in the home for personal use — leaving the anomalous situation that this consumption-related behavior is, in most states, still a felony."

Dr DuPont, who continues to oppose legalization of the drug, said home-grown pot "will generally be less potent than most imported supply," and people who grow their own "will no longer be in contact with dealers who may offer other illicit items for sale."

He said decriminalization does not appear to have caused a marked increase in marijuana use compared to states where possession remains a crime, and he said cultivation would not be likely to change that substantially.

. . . LA police chief has big reservations

CONCORD, California — A proposal to reduce penalties for growing small amounts of marijuana could make dope addicts out of two-year-old children, according to Los Angeles Police Chief Ed Davies.

The police chief, who is an undeclared candidate for governor of California, said he was referring to the move in the Assembly to eliminate arrests and prison terms for growing six or fewer marijuana plants.

The proposal, introduced in the State Senate Feb. 1 by Assemblyman Willie Brown (Democrat — San Francisco), would reduce the penalty for cultivation of up to six plants to a misdemeanor punishable with a $100 traffic-ticket style citation.

Mr Davis described the proposal as "the Willie Brown roll-your-own bill, so every hophead can have a victory garden."

If it passes, he warned, backyard marijuana gardens would be discovered — and used — by neighborhood children.

"Think about the great probability of youngsters finding these plants, figuring out what they are, and ingesting marijuana, chewing it, or taking it by some form, and you'll get them hooked when they're two- or three-year-olds," said Mr. Davis.

His warning came in a speech to the northern division of the California Federation of Republican Women.

. . .But green thumb smokers keen

NEW YORK — Economics and health are the major reasons why many marijuana users in California would be happy to grow their own pot, even though it might be inferior to imported material.

This is the feeling of Gary Stimeling, science editor of the magazine *High Times*. He told **The Journal:**

"Smokers are dissatisfied with the prices they have to pay, there is some question of how much Mexican marijuana is being imported with weed killer on it, and there is the possibility that high nitrate fertilizer used to increase yield may produce a carcinogenic danger when the leaf is smoked."

It is not going to be as easy as it sounds, however. And Americans have been unable to discover the secrets of curing the leaf once it has been grown.

Mr Stimeling pointed out there is no such thing yet as an American strain of the marijuana plant. Seeds of strains from Colombia and Thailand, for example, are imported and planted mainly in southern California and Arizona where the climate is suitable.

The most productive variety is *sinsemilla*, with the highest yields being produced by unfertilized female plants. The ideal medium to grow it in, is a green house.

Mr Stimeling said: "You have to grow it where there is little wind so as to eliminate, as much as possible, the chance of fertilization as the possibility of drift pollen is very high.

"Then you have to weed out all the male plants, but that can't happen until they have flowered as this is the only time you can tell the differences between the sexes. You have only three or four days at the most to do it."

But nature is not that simple: many of the plants are hermaphrodites and picking off the male flowers is tedious.

The hard work can be rewarding because "for some reason the female plant when it reaches the time to be fertilized, and it is not, secretes an abnormal quantity of resin."

Growing choice leaf is one thing, curing it is another. Here the Americans are stumped and it is one reason why "home grown" has an alfalfa-like taste.

"This is something a lot of people would like to know," Mr Stimeling said. "We really don't have much specific information on that."

Many observations have been made of the curing techniques used abroad, and drying sheds and hanging the plants upside down have been tired. "But for some reason the end results just are not the same. It seems there is some information missing."

Mr Stimeling believes many people in California will start to grow their own for another reason: "A lot of them have green thumbs and when they can enjoy the fruits of their labor like that, they are going to want to smoke it."

Marijuana smokers would rather grow their own pot for economic reasons, but growing it properly is a problem, according to High Times science editor, Gary Stimeling.

Final report should be out in 1978

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tion problems vary from region to region, he added.

"We don't have very much drug addiction other than alcohol in this part of Canada, for example. Yet on the West Coast, heroin addiction is a major problem."

Dr Reid said his study will also try to determine what factors facilitate or impede change and evolution in alcoholism and drug dependence treatment.

"There are agencies which have been in existence for 20 years and have not changed their program at all during their entire life span."

He said the project eventually could result in a book he plans to call *From Temperance to Treatment, The Development of Alcoholism and Drug Addiction Treatment Programs in Canada.*

"This book will attempt to look at what's happened in the last 25 years, and at the state of these programs in the country right now."

One key to success, particularly in the treatment and rehabilitation of the problem drinker, seems to be a continuum of care, Dr Reid said.

One section of the final report for the spring of 1978, will deal with the availability of care and the development of new agencies during 1975 and 1976, another will address itself to the potential client population and its composition across Canada.

"One section will be called the social organization of treatment and look at the impact of all the day-to-day problems agencies face, such as funding, staffing, policy-setting, and effects on service delivery."

Another section of the report will deal with the political economy of alcoholism and drug addiction treatment. "It will deal with the effect variations in the provincial coordinating structures of foundations and commissions have on the treatment system."

Dr Reid said there is "a lot of evidence that policy in Alberta has yielded treatment agencies very much different from the type of agencies we have here in Manitoba, for example."

"There's no doubt that some agencies are doing a very good job," Dr Reid said. "What stands out for me as I go across the country are some of the small places where the individuals are not necessarily people with a lot of degrees but people with a lot of common sense, and a hell of a lot of commitment to what they are doing, and who put in tremendous amounts of time and concern and caring for the people who need the help.

"It will be my hope always that little agencies like that receive continued support and be allowed to flourish."

Dr Reid criticized some of the big planning agencies for being too impersonal, academic, "bureaucracy-bound," and remote from the real problems of the alcoholic and the individual counsellor trying to help him, really to provide assistance where it is urgently needed.

"We have too many $25,000-a-year bureaucrats making plans in their large board rooms — too many sanctimonious grand plans — for my liking," he said.

New non-addictive pain killer is being studied

Major L. Cohn

SAN FRANCISCO — Researchers are investigating a new compound which could lead to the development of powerful pain-killers that produce neither addiction nor dependence.

Preliminary tests with a new analgesic agent called SR-13 have shown it to be superior in many respects to morphine while having none of morphine's addictiveness.

The results of experiments with SR-13 were reported to the American Society of Anesthesiologists by Major L. Cohn, director of anesthesia research at Magee-Womens Hospital and professor of anesthesiology at the University of Pittsburgh School of Medicine, Pittsburgh, Pa.

Tests showed SR-13 to be more rapid acting than morphine, taking effect within only 2-4 minutes of administration while morphine takes about 14 minutes.

The new agent was shown to be a potent analgesic able to eliminate pain after severe traumatic injury.

Besides its pain-killing qualities, it gave a high degree of protection against heat exposure, which would make it suitable for use with burn patients who frequently have to be sedated.

Unlike morphine, SR-13 does not produce depression and muscular rigidity at high doses, Dr Cohn said.

Thus is does not interfere with walking.

Most important, it does not alter the abstinence syndrome of animals addicted to morphine, which suggests that it does not bind to morphine receptors and does not produce cross tolerance with opiates, he added.

Although the biochemical structure of the new agent is still being clarified, it is known to be a non-peptide of low molecular weight.

SR-13 is a naturally occurring compound found in the brains of all vertebrates.

It was first identified by Dr Cohn and his coworker M. Cohn, C.R.N.A.

Street drinkers are now subject to $50 fines in San Francisco.

San Francisco nabs its street drinkers

SAN FRANCISCO — A new program to combat street drinking by fining offenders $50 has met with initial success here.

Ten men arrested since the program went into effect were given until February 1 to pay the fines, said a spokesman for the district attorney's office.

Anyone not paying will have his year's probation terminated and serve a 30-day jail sentence.

Deputy District Attorney Paul Cummins said the policy does not apply to persons arrested for public drunkenness, but only to those caught drinking in public from open containers.

He has asked arresting officers to confiscate bottles, cans, and bags to use as evidence should the cases come to trial.

"This is a method of drying up their ability to purchase the liquor in stores," said Mr Cummins.

Merchants and others in the downtown area have complained that public drinking had been increasing recently, which gave impetus to stricter enforcement of fines.

Now most offenders can expect to be fined, the police say.

Drug interaction studies are showing promise

By David Milne

SAN FRANCISCO — Quantitiative studies of how alcohol and sedatives interact in an animal model are beginning to explain why this drug combination can produce unexpected and sometimes deadly results.

From preliminary experiments it appears when alcohol and a sedative are metabolized by the same enzyme system, they inhibit the metabolism of each other.

The result is prolonged disappearance rates and higher blood levels of both alcohol and the sedative.

Evidence to support this "mutual inhibition of metabolism" was presented in a paper to the American Society of Anesthesiologists by Lester C. Mark of the College of Physicians and Surgeons, Columbia University, New York.

Dr Mark reported on experiments in dogs where at intervals of one or more weeks, intravenous injections of ethanol and pentobarbital were given according to the following protocol: 1) 20 mg/kg of pentobarbital in three minutes, 2) 1.5 mg/kg of ethanol in 10 minutes, and 3) the same dose of ethanol followed by the same dose of pentobarbital.

The clincial effects were recorded and serial blood samples were drawn at regular intervals over the next five to six hours and analyzed for the levels of ethanol, its metabolite acetaldehyde, pentobarbital and its metabolites.

As expected, the clinical effects were more pronounced with both drugs together than either alone.

The most striking results were that the half-time disappearance of ethanol was 60%-100% longer in the presence of pentobarbital while the plasma half-life of pentobarbital was prolonged by 50% in the presence of ethanol.

The volume distribution of each parent compound was unchanged.

Similar results were obtained in another experiment with ethanol and diazepam.

The metabolism of ethanol was slowed by 40%-300% in the presence of diazepam compared to the results with pentobarbital.

Although the plasma half-life of the parent compound diazepam was not significantly altered in the presence of ethanol, the half-life of its principal metabolite desmethyldiazepam was prolonged by 50%-300%.

These results may suggest that because of their slower clearance rates alcohol and diazepam are probably a more dangerous combination than alcohol and pentobarbital.

Most studies elsewhere have demonstrated induction and/or inhibition of metabolism of either ethanol or the interacting agent, but not both," said Dr Marks.

Heavy drinkers exhibit both acquired tolerance of the central nervous system to the depressant effects and also induction of hepatic microsomal enzymes mediating drug metabolism.

"Induction of microsomal enzymes helps to explain why alcoholics, when they are sober, are less affected than other people by barbiturates and other sedatives.

"On the other hand, during a single period of acute ingestion of alcohol, any individual may exhibit a markedly enhanced sensitivity to the depressant effects of barbiturates and other sedatives.

"This has been recognized as a reciprocal potentiation of sedative effects, but the underlying mechanism, including the possibility of a metabolic interaction, is still to be elucidated."

Dr Mark feels that results with the animal model verify quantitiatively the clinical hazards of the two drug combinations studied so far.

He believes the model is a promising beginning to the investigation of ethanol-drug interaction in vivo.

His coworkers are Dr Leonard Brand, Sofia Heiber, BS and James M. Perel, PhD of the departments of anesthesiology and psychiatry, College of Physicians and Surgeons.

PCP users show extreme effects

SAN FRANCISCO — Chronic abuse of the veterinary anesthetic phencyclidine (PCP) is producing cases of some of the most extreme behavior toxicity drug experts in this area have ever seen.

Toxicologist David Smith, who has testified in two recent cases in which chronic PCP abusers have been charged with multiple murders, says "there has been a dramatic increase in PCP abuse in the San Francisco area because the drug has become the 'in thing' for many young people."

The drug is easy to obtain from black market laboratory sources. Usually it is in crystal form and sprinkled on oregano or marijuana and then smoked.

(Investigators at the Addiction Research Foundation of Ontario have also found severe effects of PCP in a study of nine users. Overdose patients ranged from alert to comatose, and all showed a prolonged recovery phase with agitation and toxic psychosis.)

Dr Smith, medical director of the Haight-Ashbury Free Medical Clinic, says PCP "is the most disruptive drug I have ever seen." It can produce combativeness, catatonia and convulsions in a wax and wane pattern that can last from eight to 24 hours, he says.

In one case in which Dr Smith has testified, a 25-year-old male chronic PCP abuser was charged with stabbing a pregnant woman, killing the fetus, and then stabbing to death the woman's 22-month-old child. He was found by police covered in blood, wandering the strees shouting "I'm Jesus."

In the second case, a 19-year-old man, also a chronic PCP abuser, was charged with shooting his father, mother, and grandfather, and then stabbing them repeatedly with a chisel.

Problems of PCP abuse will be discussed at the National Drug Abuse Conference in San Francisco in May, by Steven Learner, who has done extensive research on the drug, and produced a film used to train doctors to recognize the signs of PCP abuse.

David Smith

Winnipeg disulfiram trials are most encouraging

WINNIPEG — A University of Manitoba psychiatry professor says clinical trials with disulfiram implants for alcoholics are so successful, the treatment method could be in world-wide use within a few years.

Clinicians and patients here have been the first to carry out implants on a large scale with detailed anaysis of results.

The results of the program, which started in January, 1974, are "highly encouraging," Allan Wilson, a psychologist and associate professor of psychiatry, said in a recent interview with **The Journal.**

Seventy percent of about 150 patients who had disulfiram implanted into the side of their lower abdomen during the start-up phase of the program, have abstained from drinking for more than a year after the effect of the implant wore off.

"We are tremendously pleased with this record and hope to remove some of the remaining doubts in certain areas of the treatment after another phase, which will give us information pertaining to about 300 patients," Dr Wilson said.

Disulfiram has been used to a limited extent in France for several years, with the treatment based on the proven fact that the drug precipitates nausea, vomiting, hot flushes, raised blood pressure, and sometimes cardiac problems, particularly when used orally before alcohol intake.

Researchers in the United States have conducted limited clinical experiments with implanted disulfiram, but mainly for purposes of treatment of individuals rather than to learn more about the efficacy of the technique.

The Manitoba study is the first one zeroing in on the long-range results of implant therapy in a large number of patients.

Dr Wilson said about 20% of his patients are women. Twenty patients were so unsure of the results of rehabilitation treatment they received during the 18 months the disulfiram worked in their systems, they asked for and received second implants.

Disulfiram inhibits the production of a liver enzyme which is essential for breaking down acetaldehyde, a toxic substance resulting from the initial interaction of alcohol with the human liver.

When disulfiram prevents the liver from changing acetaldehyde into carbon dioxide to be excreted, and a number of other substances the body can use, violent illness of various duration ensues.

"We are at the point now where we think the technique is effective enough to be used as a treatment modality," Dr Wilson said. "We now want to refine the technique to maximize its effectiveness, to maximize the incidence of a person being sick if he or she drinks after implantation."

Implantation disulfiram is dispensed surgically by being placed in a circle consisting of eight tablets, inserted through one small, straight incision. Placing the tablets in a row near the incision would invite the possibility of immune reaction and rejection through the incision wound.

"There's no doubt this is a highly effective treatment technique," the psychologist said. "We have compared the implant patients with a control group who don't have implants. What we have found is that the control patients begin drinking much, much quicker following their initial contact with treatment facilities and starting on treatment."

Dr Wilson explained disulfiram itself does not cure a patient's alcoholism. Instead, it makes it less likely for the patient to drink during the course of various rehabilitation and motivational treatment approaches.

Dr Wilson said the number of patients whose disulfiram implant results have now been analyzed is "still a little too small. The more patients you have, the higher is your credibility in the end — so we hope we can do another 150 or so. By the time we have data on about 300 people, there will be very little quibbling with our results."

40,000 articles, 1,500 books up for sale

MADISON, Wisc. — For Sale. One library. No joke.

The buyer will receive some 40,000 articles, 1,500 bound volumes, plus a unique filing system for it all.

This is the serious offer being made by STASH, a self-supporting organization that publishes *Journal of Psychedelic Drugs* and *Grassroots*. Economic times are hard and something has to go, and that includes staff and the library.

Librarian Sandy Norris said that while the library is 10 years old it contains material going back into the 1800s. The original focus was cannabis, but for the past five years articles on any substance that can be abused have been included.

How much? Ms Norris said: "We are trying to get an assessor from the University of Wisconsin here who deals with archives and special collections to help us with a price. Different figures have been bandied about, from $20,000 to $100,000."

The buyer will also get a unique classification system that has been worked out by the staff, and is used to index the current awareness publication *Speed* which is also slated to go.

Through the decade STASH has lived on money it has made and received no direct government grants. Some income has come from the National Institute on Drug Abuse for a pamphlet series.

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Comment

Northern liquor laws: local choices are best

By John Shaughnessy

AMENDMENTS to the liquor laws in Canada's north may mean more in the war on alcoholism than anything so far attempted.

Each community can now set its own liquor policy. And given the choice, a number of them in the Northwest Territories have opted for outright prohibition or strict liquor rationing. (See The Back Page).

In Rae-Edzo, 60 miles northeast of Yellowknife, it is now illegal to have liquor under any circumstances, at any time. In Frobisher Bay, the government liquor store has been closed. In Pond Inlet and Fort Resolution, rationing systems have been established. And 15 more northern communities are expected to make their choice this year.

To most of us, prohibition in the 1920s style conjures up romanticized images of speakeasys, flowing booze, and fun. No one suggests that it seriously reduced liquor consumption.

But in the north, prohibition (or rationing) seems to have a chance. The communities favoring it are relatively small and isolated. The widespread use of alcohol is not an ingrained tradition. And most important of all, the liquor restrictions are not being imposed by outsiders — they are being chosen by the people themselves.

Compared to earlier, almost chaotic conditions, life in communities such as Rae-Edzo has taken a marked turn for the better since liquor restrictions have been instituted. Liquor-related crime has dropped off substantially, school attendance has improved, and a restful night's sleep is no longer a rare occurrence.

Liquor is still being consumed in these communities, and people still get drunk, but drinking styles have changed. The hell-raising weekend, the night in jail, the court appearance, the few hours in a hospital have, at least temporarily, been replaced by less destructive drinking patterns.

No one can predict whether the initial benefits of the liquor restrictions will stand the test of time. But in a sense, this may be less important than the way in which they came to these northern communities.

The native people chose the liquor policy they thought best for them. If it doesn't work, they can choose another. Whatever the choice, the chances for success seem much greater when the local community makes it.

Inside Science

Addiction and the CNS

By Mary Ann Linseman

Many addictive drugs are known to produce tolerance when administered repeatedly to animals or man. That is, a higher dose of drug is required on successive administrations to produce the same effect, provided the interval between administrations is sufficiently short.

Practically, this means, for example, it requires more drinks for an habitual drinker to feel the effects of alcohol than for a new drinker. This is partly due to what is referred to as "metabolic tolerance" — that is, the number of enzymes in the body that metabolize the drug, is increased in the habitual user such that it is eliminated from the body more quickly and less remains to affect one's behavior.

However, this cannot account for all of tolerance shown since, even when blood levels are equated, the drug is still less effective in the chronic user.

This component of tolerance is generally referred to as "central tolerance" and it refers to the fact that the central nervous system (CNS), which controls most of an organism's behavior, has apparently become less sensitive to the drug. This means changes have occurred in the CNS to combat the effect of the drug and thus, a greater amount of the drug is subsequently needed to reproduce its original effect.

As one becomes tolerant to a drug, one also begins to show signs of physical dependence or addiction. This means actual physical symptoms, called the withdrawal syndrome, appear when levels of the drug in the body decline. These symptoms appear as the CNS, in a sense, "undoes" the change previously required to counteract the drug; in the case of a depressant drug like alcohol or an opiate, the CNS is highly excitable during this period. These withdrawal symptoms may themselves become part of the motivation to continue taking the drug.

Identifying the part(s) of the CNS where changes occur as tolerance and dependence develop, and characterizing the nature of the changes occurring there, is therefore fundamental to understanding the physical basis of addiction, and thereby to being able to reverse or prevent it by physical means.

Although alcohol is the more common drug of abuse, the opiate morphine has been more often used experimentally in attempts to answer these questions. This is because it is easier to produce physical dependence in experimental animals with morphine, and withdrawal from morphine is more readily measurable and can be observed at the discretion of the experimenter upon administration of an antagonist. For both ethical and practical reasons, most experimental studies involve animals, — most commonly rats, mice, and rabbits.

Attempts have been made to identify the locus of physical dependence on morphine by lesioning parts of the brain and observing the effects of these lesions on a subsequently-induced withdrawal syndrome. The rationale for this method is, generally, that removing the site in which changes have occurred to produce dependence, should reduce the intensity of the withdrawal syndrome.

To date, several sites, both cortical and subcortical, but loosely all parts of an area generally referred to as the limbic system, the part of the brain believed to be related to emotional behavior, have thus been implicated in physical dependence to morphine.

A second common method used to localize phenomena within the CNS, is that of direct chemical stimulation. In this case, the antagonist naloxone has been directly applied locally to many structures within the brain of animals already made dependent on morphine, and comparisons made of the intensity of the withdrawal produced. The most sensitive sites identified in this manner are in the midbrain area, including areas which when stimulated, appear to block pain. More recently, it has been shown that very small amounts of morphine itself, delivered only to this area over several days by a minipump implanted in the animal, can produce physical dependence.

One can also record the activity within the CNS to determine whether it is changed by chronic drug administration. This may include recording from large areas of the brain, as when EEG or evoked potentials are recorded, or may be from the single cells which make up the CNS.

Such studies, whether recordings from brain in an intact animal or from parts of the CNS in isolation, in response to drug administration, have shown that many parts of the CNS show changes indicative of drug tolerance. It is not yet possible to say, however, whether these changes occur at drug concentrations that are actually attained during normal drug use, or whether they are direct effects of the drug on that structure and not on another which in turn influences the activity of the first.

Most recently, it has been possible to identify actual opiate receptor sites within the CNS. Interestingly enough, these appear to be concentrated in areas whose importance had been suggested by the earlier lesion and chemical stimulation studies, i.e. the limbic system and mid-brain.

In summary, there is much evidence that drugs affect several areas of the brain, and neurotransmitter systems within the brain, in ways indicative of tolerance. In addition, manipulations made within the brain affect tolerance and dependence produced by drugs.

Further research will addresss such questions as which of these are direct and specific effects of the drug, whether one or more sites or changes are involved, and which of these are common to, or differ from, the many apparently addictive drugs.

* * *

***(Dr Linesman is a scientist in the psychological studies department of the Addiction Research Foundation of Ontario).**

... Letters to the Editor ... Letters to the Editor

Marijuana law reform gets too much space

AT WHAT point, in terms of column inches of space, does coverage of a particular event or conference cease to be reporting and become advocacy or "pushing"? It seems to me that the space devoted to the fifth annual conference of the National Organization for the Reform of Marijuana Laws in the January and February issues of **The Journal** is getting somewhere near the line.

No doubt I have noted this coverage because I am strongly opposed to the aims of this organization. They seem to have a strange appeal for the media — perhaps in the same way that a predator's victim is fascinated by his destroyer — and have enjoyed, for some time now, very favorable publicity. I know from other sources that many former friends of the reformers who would liberalize or eliminate marijuana laws, have become strong opponents of such action.

It would be interesting and useful to hear from them as a positive counter to the NORML propaganda.

Thank you. I write this protest because your publication is such an important medium of information about the alcohol and other drugs scene. Because I rely upon your publication so much, I need from you more complete and balanced coverage of the issues.

Harry W. Beardsley
Public Relations Manager
Preferred Risk Mutual Insurance Company
Des Moines, Iowa

It's a fine poster on inhalent abuse

The Journal, September, 1976, featured a poster on inhalent abuse by young people used in a public awareness program of the Canadian Mental Health Association. This poster is one of the finest I have seen on the subject, both in graphic detail and message content, and had a definite impact on all who saw it.

We would like very much to display this poster in the Community Life Center area of the United States Army Training Center at Fort Dix, New Jersy, in an effort to further educate the approximately 20,000 civilian dependents of military personnel.

Kenneth Wade
Admin Officer
Dept of the Army
US Army Training Center
Fort Dix, New Jersey

Inhalent abuse by young people — the subject of a public awareness campaign of the Canadian Mental Health Association, impressed readers of The Journal when above poster appeared in the Sept 1, 1976 issue.

Marijuana liberals sought

We are having great difficulty in locating presenters of research or studies for the Maryland Drug Abuse Research and Treatment Foundation, Inc, International Symposium on Marijuana (Sept 10-12, 1977) whose findings could be called "pro-pot."

Your readers are urged to submit brief summaries by July 15 to us at the address below.

A. V. Milliman
Director, M-DART
222 E. Redwood St
Baltimore, Maryland

Drama project on drug use is successful

On behalf of the Monmouth County (New Jersey) Narcotics Council, I am pleased to inform you of a successful project which the council began in early December. As part of its prevention effort, the council is sponsoring a professional acting company in the part of a family drama concerning the use of drugs.

The forty-minute play is followed by panel discussion emphasizing available services in the county, the reasons why people use drugs, and ways and means of preventing and educating people about drugs. The play and panel are an effective communication tool that have been enthusiastically received by audiences.

We are quite pleased with the success of this endeavor. We have received numerous requests from civic organizations throughout the county for presentations of the play/panel.

We hope to report back to you at the end of 1977 on the success of this education effort. So far, we are quite pleased.

Barry Johnson
Assistant Director
Monmouth County Narcotics Council
West Long Branch, New Jersey 07764

Backgrounder

Heroin maintenance: It will have to be tried

By Harvey McConnell

WASHINGTON — No matter how well informed the guess, the only way to find out if a heroin maintenance program will work in America is to try it.

Even then, definite answers will not be provided by an experimental program, but at least it will create a foundation for future decisions, according to Paul Danaceau in a report for the Drug Abuse Council here.

The report examines the administrative, social, and legal issues involved, and contrasts the situation with Britain where heroin maintenance is legal.

The debate in America is not new: between 1912 and 1924, some 44 clinics for addicts were established. Then the law changed and America moved to regard heroin as primarily a criminal problem, while the British regarded it as a medical problem.

This basic difference remains today, although American government support of methadone maintenance programs during the last 10 years has expanded the opportunity for addicts to enter treatment programs.

A striking feature of heroin maintenance in Britain is its general similarity to most American methadone maintenance programs.

The report points out: "Addiction is defined as a medical problem; physicians are in control of the clinics; and nobody receives an opiate without prior proof of addiction."

However, there is a crucial difference: "British doctors can choose whatever drug or method of treatment they feel is most appropriate to the individual addict.

"American physicians, on the other hand, are limited by law in their treatment of heroin addiction."

At present in Britain, methadone is used more than heroin, and while it was usually administered intravenously, there is a shift there now towards oral administration, the norm in America.

A number of important administrative issues would have to be decided before any heroin maintenance program could start in the US. Vital ones are eligibility and age.

Would a program be limited to people who have been regular heroin users for a long time, or would people with low-level heroin habits be admitted? A watch would have to be kept to avoid inadvertently admitting the casual user.

As for age of admission, the report points out that it took the Food and Drug Administration several years to decide on lowering the age for methadone maintenance programs from 21 years to 18 and adolescents are admitted only under special circumstances.

> **"There can be no heroin maintenance without the support of minority communities, organizations, and individuals."**

The difficulty is that more than half of all American addicts acquire their addictions before reaching the age of 21.

Heroin dispensing may have to differ from the British system because of physical numbers. In Britain there are an estimated 3,000 addicts, while the estimate for the US is between 300,000 and 400,000.

A prescription system would keep costs down, but it could also lead to difficulties, ranging from diversion of the drug to the streets, to addicts injecting themselves in non-sterile settings.

Heroin administration within a clinic would increase costs but minimize the risk of diversion. However, as heroin is a short duration drug, many people would need to attend a clinic several times a day.

A combination might be feasible — clinic attendance on some days and use of prescriptions at pharmacies on others.

Turning to the heroin black market, the report points out: "It would take a heroin maintenance program of vast proportions to have any impact on the black market. Even then, it might be several years before the results of the effort could be evaluated."

There would remain demand for heroin, as there is now in Britain, from patients who want to supplement their clinic heroin, addicts who are not part of a program, people in the early stages of addiction, and the casual user.

The report says it is not known how much crime is actually committed to support illegal heroin habits.

Police and court records do not contain this information. "Estimates vary anywhere from 10% to 50% of all revenue-producing crimes, depending upon the offence and the city, but they are not particularly reliable," the report notes.

The individual addict would gain some immediate advantages from a maintenance program : an end to drug hunger and reduction of the hazards of infection, poison, and overdose from illegal heroin.

Less clear, the report continues, is whether the addict would be motivated to make changes in his life, such as finding a job, raising a family, going back to school, or even giving up heroin altogether.

Some street addicts say a program would make it easier to do this "but most are much more likely to regard heroin maintenance as a reliable source of legal, safe, and inexpensive heroin," the report adds.

It emphasizes: "There can be no heroin maintenance without the support of minority communities, organizations, and individuals.

"The problem is, however, that individuals who favor heroin maintenance, who favor it under certain conditions, or who would not oppose it, are reluctant to express their views politically."

On the other hand, opponents in the black, Spanish-speaking, and other minority communities are not reluctant at all to speak out.

The report says: "Many of them believe heroin maintenance is a form of genocide at worst, and social control at best, and an effort to keep minority communities tranquillized on drugs and to render them socially and politically ineffective and impotent."

Another view is that heroin maintenance is a law and order issue and would put an end to concern for the welfare of the addict.

The legal problems are formidable. Permission to use heroin in research programs would have to be given by the Food and Drug Administration, the Drug Enforcement Administration, and finally the National Institute on Drug Abuse, which would actually make the drug available.

The report continues: "It is impossible to say at this time what kinds of concerns NIDA might raise; whether NIDA approval would be automatic once DEA and FDA approval had been obtained; or precisely how the heroin would be made available to the researcher."

It concludes that some will argue addicts enrolled in a program would be worse off than before. Others will claim that an informed observer of the British and American scenes could predict the outcome.

"But as it would be poor public policy to develop, or not develop, an experimental program on the basis of the British experience, it would also be poor public policy to rely on guesses and inferences, no matter how informed, to predict the outcome."

The Journal welcomes Letters to the Editor and notifications of Coming Events from its readers. Both letters and Coming Events notices should be sent to: The Journal, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada, M5S 2S1.

Huk Sai Wui established in 4th century

Chinese triads are replacing French connection

By Thomas Land

PARIS — The Triads, a network of ancient Chinese associations with something like a million members scattered the world over, appear to have taken over the lucrative European black markets for hard drugs, controlled until recently by the notorious French Connection.

A disturbing rise in drug addiction in France and Britain and a corresponding increase in arrests on both sides of the English Channel of drug pushers supplied from Amsterdam, the major European distribution centre used by the Triads, may well lead to new diplomatic efforts this year to find a common solution. Both the French and the British authorities believe that, unlike the highly concentrated French Connection, the elusive network of the Triads can be smashed only through cooperation with the opium poppy growers of the Far East.

Police in Holland have carried out recently several big raids on the drug rings; but they may have acted too late. During the past two years, the Triads have established firm and relatively secure transport, storage, and distribution facilities in and around Amsterdam. Their sales network now embracing much of Western Europe appears to employ largely European youngsters, themselves addicts, whose arrest yields no significant leads for further investigation.

The Triads take their name from the triangles involved in their initiation ceremonies. Known in Chinese as Huk Sai Wui or the Black Associations, they were first established in the fourth century and were then concerned with religion. Some of their members emigrated to Western Europe and North America in the 19th century.

Until the breakup of the French Connection in 1974, much of the black market of Europe and North America depended on heroin prepared in the illicit laboratories of Marseilles in the south. The organization was destroyed through cooperation by the French and North American narcotics agencies. Heroin use consequently dropped by French drug addicts from an estimated 38% in 1971 to a remarkable 5% in 1975.

But fresh authoritative surveys now put the proportion of French heroin addicts at 17%; and there was a record of nearly 60 deaths in the country during 1976 clearly related to the illicit trade. The most common form of the drug available here is "brown sugar" manufactured in the Far East with the addition of morphine, codeine, or caffeine, flown to Amsterdam, and distributed from there by large numbers of smalltime operators as well as a few well organized professionals.

According to the Marmottan Hospital here, which works with drug addicts, the majority of the traffickers recruited in Amsterdam are addicts aged between 18 and 25 years.

A secret memorandum circulating in Britain's Home Office (a kind of department of the interior) whose contents were made available to this correspondent late last year appeared to confirm a similar trend across the Channel. It described an influx of Chinese heroin from South-East Asia and warned that hard drug addiction was perhaps already out of control.

A subsequent survey prepared by the department of health found official addiction figures in Britain misleading because they failed to take into consideration a growing number of addicts not officially registered for treatment. And, the annual report of the Standing Conference on Drug Abuse estimated addiction in Britain increased by 10% a year because of the recent growth of the illicit trade.

The secret memorandum observed: "Estimates of heroin likely to result from the unlawful cultivation of opium in South-East Asia suggest the quantity available would very substantially exceed any possible scale of local consumption and might result in a very substantial surplus for illicit export . . .

"There has certainly been an increase in the amount seized (in Britain) in the first part of 1976. It had previously been assumed that much of the drug seized here was in transit (to North America) but it is no longer possible to be so certain of this."

Specialists at the French narcotics office consider the nature of the new drug distribution network involving many loosely related small operators, allows little hope for a spectacular single swoop to bring the heroin trade to an end. Their colleagues in London agree. They want their countries to bring diplomatic pressure on the producers of South-East Asia to control drug trafficking at source.

France and Britain were the major force, together with West Germany, in discussions last year aimed at bringing the police forces of the European Community into closer cooperation against international crime such as drug trafficking and political terrorism. This year, they are likely to explore the possibility of committing the entire Community to subtle but intense diplomatic pressure, including the implied threat of trade sanctions, to force the opium producing countries into cooperative action.

Annual Kiwi intake

This is how a New Zealand newspaper, The Auckland Star, illustrated that country's annual alcohol consumption. The year's supply of alcohol for the three average Kiwis in the photo is based on the average per capita consumption of 133.1 litres of beer, 8.5 litres of wine, and three litres of spirits.

Damaged babes costly

MUNICH — Alcohol abuse by pregnant women may be causing more physically deformed and mentally handicapped children in West Germany than did the use of thalidomide drugs in the 1960s.

According to Professor Manfried Lieber, director of Frankfurt University's Department of Semiotics, alcohol abuse during pregnancy may now be the most frequent cause of damage to unborn babies.

Dr Lieber warned that one out of three women who drink regularly must expect their children to be born either deformed or mentally handicapped.

He listed stunted growth, deformed fingers, skull deformitories, congenital heart, and eye conditions as likely disabilities and estimated that special care and treatment for such children will soon be costing the public from $125 million to $250 million annually.

The number born each year is 6,000 — about the total number of those who suffered from thalidomide deformities in Germany before the drug was taken off the market.

Dr Lieber's findings have been substantiated by a team of researchers at Tuebingen University's Children's Hospital where 60 children with an embryonic alcohol syndrome have been born within the past two years.

According to Professor Juergen Bierich, the director of the hospital, the syndrome is clearly recognizable.

"In addition to organic deficiencies," he said, "they have typically deformed faces such as drooping eyelids, broad Mongoloid-type noses with wide nostrils, thin-lipped mouths and drooping folds around the mouth."

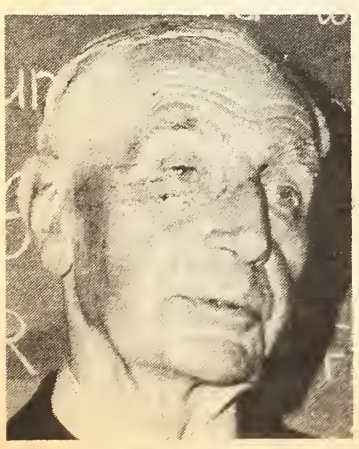
According to Dr Bierich the most critical period is during the first three months of pregnancy.

Myths obscure role of vitamins in alcoholism

By Pat McCarthy

WELLINGTON, NZ — Large amounts of vitamins, particularly the fractions of the vitamin B complex, are prescribed to sick alcoholics with little or no evidence they are necessary in a majority of people who overindulge in beverage alcohol, a physician here believes.

Like the "wet brain" condition so long regarded as the outstanding pathological disorder in delirium tremens, the reputed need for large doses of vitamins in chronic alcoholism, particulary in the stage of withdrawal, has gained widespread acceptance through constant repetition, Charles Burns told the Summer School on Alcohol Studies.



Charles Burns

He said vitamins are necessary in alcoholics who have become severely debilitated, not only through the amount of alcohol consumed over a long period, but through their intake of other dietary factors being markedly limited.

The amount of vitamin B1 used by the body in a state of health is not more than 1 mg a day. Since this vitamin cannot be stored, any excess taken by mouth is just excreted.

Sir Charles, consultant physician to the National Society on Alcoholism and Drug Dependence, said it is recommended in Conn's Modern Therapy that not more than 3-5mg of vitamin B1 need be injected as an initial treatment for Wernicke's syndrome. This is a mental condition in which Thiamine is indicated as an urgent need, preferably at the stage of the initial ocular palsy.

"Yet it has become customary to inject 100mg, often daily for several days intravenously or intramuscularly, clearly to little or probably no good purpose unless the patient is quite unable to be fed orally," Sir Charles said.

Vitamin B1 is also urgently needed in the presence of beriberi heart, he added.

Niacin, another member of the vitamin B complex, was formerly recommended in very large doses for alcoholics and persons suffering from hallucinatory states in psychoses.

Sir Charles said the only deficiency disorder clearly ascribed to lack of this vitamin is pellagra — a disease characterised by diarrhoea, dermatitis, and dementia. It occurs in the southern United States, Egypt, and South Africa, where corn containing insufficient amounts of this vitamin is used.

As for the use of Niacin in treating alcoholism, he said a textbook by a well known group of pharmacologists, Meyers, Jawetz and Goldfien, states "the effectiveness claimed originally that this vitamin would cure hallucinatory states occuring in alcoholism has not been verified by controlled study."

Sir Charles said a doctor must never overlook the possibility a poorly nourished alcoholic brought in unconscious may be suffering from hypoglycaemia (a very low level of blood sugar), which if untreated may lead to death.

In such cases, intravenous injections of glucose must be accompanied by a dose of vitamin B1. Without this there is the danger of precipitating Wernicke's encephalopathy, a degenerative brain disease.

The possibility of hypomagnesaemia must also be remembered, particularly if the individual is hyperventilating, because a whole range of encephalopathies may be precipitated if magnesium levels are not brought up to normal in the early stages of the withdrawal syndrome.

Sir Charles also warned against the prolonged use of chlormethiazole (Hemineurin), a sedative hypnotic and anti-convulsant commonly used to reduce serious withdrawal symptoms.

Like all centrally acting sedative hypnotic drugs, it induces dependency or addiction and only short-term use is recommended in addiction-prone patients such as alcoholics, he said.

"This should never be persisted in for more than 10 days as an absolute maximum and except in very exceptional cases should never be prescribed except to patients who are in hospital under supervision.

"Cases of Hemineurin addiction are occurring with increasing frequency in this country and the withdrawal of the drug can be as disturbing to individuals concerned as withdrawal from alcohol."

Treatment of overdosage should be similar to that for barbiturate overdosage, Sir Charles said.

Counselling is cheaper

LONDON — A highly respected British charity, the Mental Health Foundation, has claimed savings of £13 million and a cutback in the number of people dependent on pills could be achieved by the introduction of a low-cost counselling service.

It made the assertion after completing an 18-month survey during which a team of counsellors provided therapy for the patients of family physicians.

The survey, conducted by the Counselling Service Association, suggested about 50% of the patients of family physicians would need fewer drugs if they had counselling support.

People should understand steps to legal BAL

WELLINGTON, NZ — In setting legal blood alcohol levels, special attention should be given to the actual quantities of alcohol which would have to be consumed to give any level proposed, a scientist here recommends.

Volunteer studies have shown that a person who starts drinking after 5 pm and has a meal in the early evening would have to consume an amount of alcohol approximately equivalent to the quantity contained in a half bottle of gin to reach the New Zealand legal maximum of 0.1% by 10 pm, Richard D. Batt told the Summer School on Alcohol Studies.

Publicizing information on the quantities of alcohol which would have to be consumed to reach the limit might provide grounds for individuals to increase their normal intake, knowing they would still be within the law, he acknowledged. But it might also help to persuade legislators and the public to accept a lower legal limit.

Dr Batt, professor of biochemistry at Massey University, Palmerston North, heads a research group which, in 1973, began studying the quantities of alcohol likely to give a defined blood alcohol level in an individual.

The group prepared a chart based on the best mean values for Widmark ratios in the literature, with estimates of ideal body water contents derived from ideal body weights related to height and frame classifications.

It was assumed the alcohol was consumed rapidly and before a meal. The values calculated correspond closely to data from studies on volunteers.

As an example, it was calculated a male of 5ft 8in and medium frame size would have to drink 10 seven-ounce (200ml) glasses of beer (alcohol content 2.8 w/v) to take his alcohol level over 0.1%. A female of the same height and frame size would have to drink eight glasses.

When this information was included in a widely distributed poster, reactions varied from surprise at the quantities required to exceed the legal limit to "frank disbelief," Dr Batt reported.

He said the effect of food on absorption of alcohol is not always recognized, yet the presence of food in the stomach had a major effect under the conditions used in volunteer studies.

The quantity of alcohol required to give a maximum blood alcohol, after equilibration, of 0.1% could be almost doubled if consumed during an hour after a meal, compared with calculated quantities for rapid drinking before a meal.

Supporting a limit of 0.05% for drivers aged 21 and under, and a limit of 0.1% for older drivers, Dr Batt said more than 40% of New Zealand drivers who are breath and blood tested in a year are under the age of 25.

Volunteer studies at Massey University make it clear most young people show impaired skills at 0.05%, he added. Many of them would find it impossible to drink to a blood alcohol level of 0.1%.

The average blood alcohol for all New Zealand drivers tested in a year is about 0.16%, he said, but the argument that a level of 0.1% would therefore seem reasonable does not recognise that this level would be "unattainable for many young drivers."

German concern for children mounts

MUNICH — West Germans spent a record $20 billion for alcohol and tobacco in 1975, according to the Federal Agency Against Addiction in Hamm, Westphalia.

This is more than a 7% increase over 1974.

The amount spent for alcohol was 33.9 billion marks (approximately $13.6 billion) and that for tobacco was 15.9 billion marks (approximately $6.4 billion). This equals more than $200 per capita expenditure for alcohol and more than $100 for tobacco.

West German beer drinkers

Although beer consumption, at 148 litres per person, remained fairly constant and represented the largest proportion of alcohol consumed by West Germans, there was a pronounced increase from 2.6 to 3 litres per capita in consumption of spirits.

Consumption of pure alcohol per person increased from 11.6 to 12.4 litres.

Cigarette usage decreased from 2,965 per capita in 1974 to 2,042 in 1975.

In the light of these statistics, West German sources are expressing special concern over what appears to be a marked increase in both alcohol and cigarette consumption among juveniles.

A survey among 2,360 adolescents aged 10 to 18 years, conducted by researchers at the University of Kiel recently, shows that some teenagers spent up to $80 per month for alcoholic beverages.

Some 15% of youths spend between $24 and $80 monthly for alcoholic beverages and another 27% spend from eight dollars to $24 a month.

Although beer is the main beverage consumed, the survey indicated teenage girls also have a proclivity for mixed drinks with spirits and the alcohol consumption rate among female teenagers is coming close to that of the boys.

More than 60% of those questioned said they drank in the company of friends their age, 14% drank with their parents, and 7% drank alone and "with considerable regularity."

There appears to be a correlation between alcohol consumption of parents and that of teenage children. More than 20% of those whose parents drink regularly do so too.

Forty percent of those questioned said they drank for "social" reasons, usually at parties, celebrations, and when visiting friends. Another 40%, however, said they drank for a variety of psychological reasons such as "tension," "depression," or "frustration." Ten percent said they drank to appear "grown up."

The study indicated teenage alcohol abuse is most prevalent in the age group of 14 to 16, although even some 11- and 12-year-olds can be classified as alcoholics.

Alcohol studies for nurses

ADELAIDE, Australia — Community nurses will be able to specialize in the treatment of alcoholism and other addictions during a one-year diploma course introduced this year at a South Australian teachers' college.

Nearly 30 trained nurses are taking the course at the Sturt College of Advanced Education, Adelaide, and all will receive some instruction in dealing with addictions.

After the first three months, they will elect to specialize for the rest of the year in one of four areas — industrial health, child health, geriatric health, or alcoholism and addictions.

"The aim is that in due course every ward in a general hospital, and all the major departments — the department of medicine, of traumatic surgery, of internal medicine, of gynecology — will have a cadre of nurses who will be counsellors in alcoholism," said Jan Gabrynowicz, medical director of the Alcohol and Drug Treatment Board in Adelaide.

You'll taste better

UK govt packs big punch for smokers

By Alan Massam

LONDON — The long-awaited British government initiative to reduce hazards of smoking has come with considerably more strength than was anticipated.

Health and social services secretary David Ennals announced in the House of Commons that:

• Cigarette packets will carry a stronger health warning that smoking can *seriously* damage health (inserting the word seriously);

• Advertising of cigarettes in the "high tar" category will be stopped immediately, and in the "middle to high tar group" by the end of next year (ads will be permitted only for the two lowest tar groups);

• Manufacturers have agreed to try to eliminate all "high tar" brands after two years and undertake not to introduce any more "high" or "middle to high" brands in the meantime;

• The Common Market (EEC) idea that cigarettes should be taxed according to the degree of danger to health they impose has been accepted in Britain.

Along with the new measures, Mr Ennals announced there would be a new set of restrictions on smoking in public places with extra funds for the Health Education Council to finance smoking and health education. This campaign will be directed especially at the young.

Mr Ennals said: "Stop the habit for its own sake. Of course it is not easy to give up; most things worth doing are not. But it is worth the effort.

"You feel better. You smell better. You taste better. And you have cash for other things."

The minister added smoking had been a habit in this country for 400 years and would not be banished quickly. But the long-term aim must be its eventual disappearance.

The government's strategy, he said, was to discourage non-smokers from getting into the habit (by ensuring the public knows the facts); to persuade smokers to give up, to cut down, or to switch to less dangerous brands; to make cigarettes themselves less dangerous to health; and to create a non smoking environment with facilities for those who wish to smoke rather than vice versa.

Mr Ennals said talks were continuing between his department, the Advertising Standards Authority, and the tobacco industry on a tighter overall code of cigarette advertising. The industry has also agreed to comply with guidelines drawn up by the department of health and social security's advisers on the testing and marketing of cigarettes containing tobacco substitutes and additives.

The Minister's statement was welcomed by medical authorities including the British Medical Association who said the establishment of a non smoking community was the most important job facing preventive medicine.

David Ennals
'Stop smoking. You feel better. You smell better. You taste better. And you have cash for other things.'

Around the World

Familial bonds

Four to five million West Germans are estimated to be affected by drug and alcohol abuse because they are close family members of addicts and alcoholics. The figure, according to West Germany's Federal Agency Against Addiction, represents from 7% to 8% of the country's population. The agency has revised upwards its estimate of the number of alcoholics in West Germany from one million to 1.5 million, of which 20% are women and 10% are under age 24.

In-flight hikes

It's become more expensive to drink on Air Canada's international flights — beer is up from 75¢ to $1 a bottle, and liquor is $2, up from $1.50. There's still relief for wine and sherry drinkers, however, because the price, for the moment, remains the same at $1.50.

Casinos aid economy

Spain has legalized gambling casinos, after more than 50 years, to boost tourism and the economy. The step is expected to draw about $500 million a year from abroad and help reduce the country's big balance of payment deficit. The government is expected to limit the number of casinos to six or seven, to be set up in Madrid and the main tourist resorts.

Doctors 'down under'

A survey of a random sample of nearly 1,300 Australian doctors showed only 14% of the medical profession are now cigarette smokers. Sixty-three percent of the doctors said they encourage all their patients to give up smoking whenever possible and a further 25% limited the advice to give up the habit to patients suffering ailments attributable to smoking. Only 1% of the doctors surveyed believed a patient's smoking habits is never the doctor's concern.

Finns finish ads

The first day of Finland's rigorous new laws to discourage smoking and drinking saw workmen removing billboards advertising liquor. Promotion of tobacco and alcohol in newspapers also ended by law recently, but cigarette manufacturers say only a price increase will cut consumption.

Bad news for gambling addicts in New Brunswick's crackdown

By John Carroll

FREDERICTION — A crackdown is in progress in New Brunswick on the use of gaming devices prohibited by the Criminal Code of Canada.

March 1 saw the first phase of the program instituted by the provincial department of justice, with Royal Canadian Mounted Police checking on six major distributors of the gambling devices to ensure compliance with a warning in early February that such devices as slot machines, "stamp" machines, and punch boards had been withdrawn.

While stamp machines and punch boards have been found in small stores and similar outlets, slot machines have been a mainstay of many private clubs throughout the province.

Officers of clubs have generally been reluctant to reveal figures as to revenue obtained, but millions of dollars annually have been poured into both electronic "uprights" and "one-arm bandits." The former record games on a counter, while the latter pay out in coins.

The situation in the province has been tolerated for about two decades, with only the odd enforcement by police authorities. The sudden shift to enforcement of Criminal Code prohibitions apparently was triggered by a growing number of complaints to authorities by individual players or their dependents over high losses.

These complaints seem to have increased in the past two or three years, coincidental with installation in some clubs of modern electro-mechanical one-arm bandits. The fact these machines pay directly in coins may have a more addictive impact on some individuals than the electronic uprights, where any money that changes hands was by means of a payment for games won.

In February, at the time of the announcement of the March 1 deadline for removal of the devices, RCMP Moncton Sub-division Superintendent Jack Rankin said machines were "very widespread . . . literally hundreds, maybe thousands" were in use in New Brunswick. Most come from the US.

In Fredericton, an RCMP spokesman said on March 2 if any of the importers of the devices were still in business, the police would seek justice department authorization to institute prosecutions.

The second phase of the attack on this form of illegal gambling will be to tackle the distributors who contract the machines out to clubs and retail establishments, and service the equipment. It is not known how many distributors, many of them small operators, are in the province, or how long this process will take.

The final stage of the purge will be to check on the various premises where devices have been operated, but the RCMP spokesman said this was likely to be some time in the future and would be done on consultation with the justice department.

The immediate impact has been that while the enforcement has been directed at importers and distributors, many New Brunswick clubs met the March 1 deadline by instructing suppliers to remove their machines.

Club officers admit the removal of the machines and the consequent loss of revenues will hurt, and there has been a round of price increases and, in some cases, increased membership fees.

Much of the public comment on the government action has been in the vein of criticism of the administration for a double standard of morality, for New Brunswick, in consort with her three sister Atlantic Provinces, had passed legislation permitting lotteries and last December the biweekly Atlantic Loto began operations.

Many citizens argue that there is little difference between permitted forms of gambling such as pari mutuel wagering, bingos, and government lotteries, and the playing of games machines in clubs where entrance is restricted to adults.

The sentiment most often expressed is that the government has acted either to reduce competition with Atlantic Loto or preparatory to licensing the machines and taking a cut. This latter suspicion flies in the face of the fact that the prohibition is in the Criminal Code and the federal government would have to acquiesce to any permissive change.

Pot use patterns in Oregon are varying little

WASHINGTON — Current adult use of marijuana has increased from only 9% to 12% in Oregon since criminal penalties for possession of small amounts of the drug were lifted three years ago.

At the same time, a majority support the present laws, and there is some indication of increased public support for further liberalization.

These are among the findings by an independent marketing firm in Portland which has carried out yearly surveys since 1974 for the Drug Abuse Council here in order to measure the effect of the decision.

In the three year period, the number of people over the age of 18 who have used marijuana has claimed from 19% to 24%. Current users have increased three percent, from 9% to 12%.

Among current users, 50% said there had been no change in their use of the drug, 39% had decreased their use and only 9% reported an increase in use.

A breakdown by age groups found that in the 18- to 29-year-old bracket the percentage who have ever used marijuana has increased from 46% in 1974 to 62% at present. Some 35% of this group said they were current users.

In the other age groups, those who have ever used the drug over the three years has risen by less than 3%, and only some 8% are current users.

Some 58% of those questioned favored the present law, or further relaxation, while 38% called for stiffer penalties.

Some 62% thought the change had had no effect, or were undecided, and 16% thought the change in the law was harmful.

Findings close to those in Oregon have been produced in a poll in California carried out by the state health and welfare agency. California changed its law in January, 1976.

"The reduction in penalties for possession of marijuana for personal use was not a major factor in people's decision to use or not use the drug," according to Mario Obledo, secretary of the health and welfare agency.

Some 35% of adults questioned reported having at least tried marijuana, but only 14% considered themselves current users.

Again the largest group to use the drug are in the 18- to 29-year-old bracket. Over an 18 month period, those who used it rose from 54% to 66% and of these, 31% reported they are current users.

Overall, 61% favored the present laws, or more liberalization, and 29% were in favor of stiffer penalties.

Anesthetizing addicts is a problem

SAN FRANCISCO — Addicts on heroin or other opiates are difficult to anesthetize and there is no ideal agent or technique for the chronic addict or those with acute opiate overdose, according to Theodore H. Stanley, associate professor of anesthesiology, University of Utah College of Medicine, Salt Lake City.

Although some opiate addicts may be managed with local anesthesia, their psychological problems make general anesthesia easier and frequently safer, Dr Stanley said in a lecture at the annual meeting of the American Society of Anesthesiologists.

Addicts come to the operating room with low blood pressure, abnormally low heart beat, and less air and oxygen in their lungs than generally required.

Their gastrointestinal tract must be handled as if the patient had a full stomach of food.

The cardiovascular changes can be reversed by incremental amounts of 0.2 mg naloxone every 5 minutes intravenously until respiration is adequate.

Support of the circulatory system with fluids and monitoring of arterial oxygen tension and pulmonary shunting is also important.

Management during surgery requires normal fluid replacement, a high oxygen concentration, frequent arterial blood gas monitoring and sometimes positive and expiratory pressure.

Giving the patient a drug antidote can reverse many of the conditions, but complete reversal of the drug effect may turn the patient into an uncontrollable menace.

If the antidotal drug action is shorter than the narcotic effect, the patient may become renarcotized by opiate anesthetic agents given him during surgery or in the postoperative period, said Dr Stanley.

All of these hazards must be considered when dealing with chronic addicts or those patients who have overdosed on opiates.

Theodore Stanley

Native people are solving their own problems

(from page 16)

attendance is much higher; fights among students nil and no longer does he see children coming to school beaten, hung over, or exhausted.

"In the library now we rarely see a kid dozing on the floor. We used to have half a dozen kids hiding in the book stacks having a sleep because they were kept up all night by drinking and fighting adults."

Even where rationing is not in effect, liquor use is actually on the wane in the north, partly, observers suspect, because of rising liquor prices, but probably more because of the rising political awareness among natives, who are being prodded and are demanding increasing powers to manage their own affairs.

"It is interesting," says an Oblate priest in the NWT, "that the native people are solving their problems with their own solution, after years of the white man's solutions failing."

To be fair, however, it is a white man, NWT Commissioner Stuart Hodgson, who has repeatedly risked criticism in exercising his executive perogative to fight the liquor epidemic. It was he who abruptly ordered the bustling liquor store in Frobisher closed without a town vote on the issue, and he who gave money to the people of Rae to organize a prohibition plebescite.

Supply stores in the NWT are few and far between. Fort Liard store (above) is located on the river of the same name and joins the McKenzie River at Fort Simpson.

A year ago, when the people of Chesterfield Inlet asked for a beer outlet so they would not have to make the dangerous 150-mile snowmobile trek overland to the Rankin Inlet beer store, he told the community: "I just can't bring myself to open a beer store here. I've seen so much hardship in places where they have liquor outlets. It would have been much better if the government had not changed the law to sell beer and liquor to Indian and Eskimo communities. We've never yet been able to solve problems that we ourselves created. The Eskimo survived thousands of years; it pains me to see them destroy themselves."

Controversy still rages in the north about the causes of native liquor abuse. Some experts, like drug and alcohol abuse worker David Gladders in Yellowknife, feel the problems are cultural, that behavior reflects what is socially acceptable. Others, like the NWT Indian Brotherhood, see intoxication as symptomatic of a colonized race who have lost control over their lives. The oil companies seeking to build a pipeline in the north, relate drunkenness to idleness and no jobs. Commissioner Hodgson, an occasional light drinker, personally subscribes to the genetic theory, that there is something in native genes or body makeup that cannot tolerate liquor.

A recent study of American native drinkers in New England found no difference between them and their white counterparts. A Canadian study completed two years ago, however, suggested that natives were deficient of an enzyme that removes alcohol from the body system.

Noting that the Frobisher liquor outlet closure did not flush out hordes of alcohol-starved drinkers in the throes of DTs, medical authorities analyzing the Frobisher Bay experiment suggest that most drinkers there were not alcoholics, in the physical dependence sense, but rather binge drinkers.

"And the real alcoholic makes sure of his liquor supply; he's usually stockpiling," says Canadian health and welfare psychiatrist Patrick Abbott.

Although the shutdown in Frobisher sparked an early spate of success stories — an Inuk carver stopped drinking, bought a snowmobile and went back to the land to hunt his own food; a Pangnirtung mother rebounded from months on Yellowknife's skid row to kick booze, get a job, and be reunited with her children; a Frobisher schoolboy is back with his parents after being put in an institution for protection from them — observers know that the true test is time.

Look what's happening at The Journal

From the United Nations in Geneva . . .

ALCOHOLISM is alcoholism whether it's in a back street in Toronto, an executive boardroom in London, or a factory in Russia.

And for a drug addict, the pain's the same whether he's in Bangkok or southern Texas.

As the problem of alcoholism and drug dependence, and the related problems of prevention, treatment, and law enforcement, are increasingly recognized as problems shared by the world community, **The Journal** is enlarging its focus accordingly.

Anne MacLennan is directing the operation. Karin Sobota is assisting.

In the February issue, Ms MacLennan, appointed editor of **The Journal** in September, 1976, examined the ways the lives of the tribespeople of the opium-producing Golden Triangle, touch the lives of North Americans. And she discussed some of the things being done by the United Nations in Geneva, perhaps the single best available weapon we have on a global scale, to deal with the problems.

Anne MacLennan

In the same issue, Ms MacLennan reported Canada's protest of the United States proposal to begin commercial cultivation of the scarlet poppy which yields codeine.

The article anticipated lengthy discussions at the annual meeting in February in Geneva of the United Nations Commission on Narcotic Drugs.

The Journal knows that, because **The Journal** was there — for the first time. In this issue, Ms MacLennan reports on some of the proceedings.

Karin Sobota

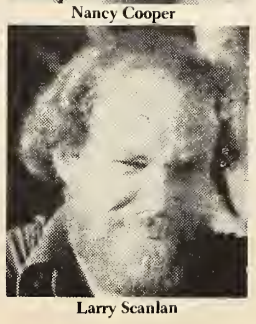
Ms Sobota, formerly a reporter with a large Toronto newspaper, joined the staff of **The Journal** in November, 1975, as editorial assistant. Her job is to assist the editor in the overall planning of each issue, and to oversee layout and production each month.

Ms Sobota also likes to keep her hand in as a reporter. One recent major contribution appeared in the December issue — coverage of the annual meeting in San Diego of the Association of Labor-Management Administrators and Consultants on Alcoholism.

To Auckland, Yellowknife, Madrid . . .

Pat McCarthy

Nancy Cooper



Larry Scanlan

MANY of our correspondents have been with us from almost our beginning in June, 1972. Recently, however, we've added a few new faces.

Pat McCarthy, a medical writer and newspaper reporter in New Zealand for the past 15 years, is now a regular contributor to **The Journal**.

Mr McCarthy, who lives in Auckland, is also a correspondent for the *Australian Medical Association's Gazette*, the *International Medical News Service* based in the United States, and *General Practitioner*, a newspaper for doctors published in Britain.

One of his most recent contributions to **The Journal** concerned new legislation in New Zealand allowing children to drink in specially designated "family lounge bars".

Nancy Cooper is a freelance journalist living in Yellowknife, Northwest Territories, Canada, in an old, converted brothel-general store. Formerly a reporter with *The Globe and Mail* Canada's national newspaper, and before that, at the *Whig-Standard* in Kingston, Ontario, Ms Cooper's recent articles have appeared in *Macleans Magazine* and *The Edmonton Journal*.

"Nothing I covered down south prepared me for the culture shock of moving north," she says. "Northern native people's values, lifestyle, and history, generally, are completely different, and after two years here I'm still contending with the knowledge that, as another transplanted southerner, I'm as likely to be part of the problem as I am part of the solution to the complex northern social problems.

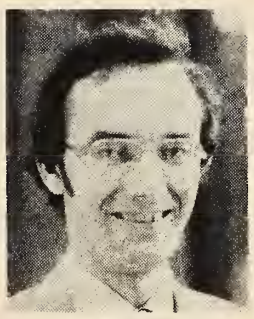
Ms Cooper's contribution to **The Journal** this month, appears on The Back Page and is an in-depth look at the way self-imposed prohibition of alcohol has affected the native people's lives.

To distinguish Larry Scanlan from our regular "foreign correspondents" we tend to think of Mr Scanlan as our "mobile stringer" or travelling correspondent.

Mr Scanlan was formerly assistant editor of *Canadian Family Physician*, published in Toronto Canada. Mr. Scanlan will be reporting on meetings and interviewing authorities on alcohol and drug dependence wherever his travels in Europe and Africa take him. His recent article on the problems Spain is facing with increasing alcoholism and drug dependence among Spanish youth, stemmed from an interview with Dr Octavio Aguar, one of Spain's leading experts on the subject.

And the pulse of Washington and Toronto . . .

Harvey McConnell



John Shaughnessy

IN NOVEMBER, 1976, two new contributing editors joined the staff of **The Journal**.

Now, for the first time ever, we have a Washington-based contributing editor.

Harvey McConnell, an American who has worked as a medical science writer in the United States, and London, England, for more than 12 years, has been keeping his reportorial finger on the pulse of the Washington alcohol and drug dependence field since then.

Shortly after Jimmy Carter was elected president of the United States, Mr McConnell reported on what Peter Bourne thought Mr Carter would likely do in this field, as president. Mr Bourne, one of Mr Carter's closest campaign advisers, is the president's special assistant for mental health and drug abuse.

In the next months, Mr McConnell will be moving out of Washington occasionally to have a look at some of the important things happening in other parts of the US.

In Toronto, **The Journal**'s new contributing editor is John Shaughnessy. Mr Shaughnessy, a well-known and respected medical journalist, was formerly managing editor of *The Medical Post*, the eminent newspaper for the Canadian medical profession.

In tandem with his duties as contributing editor, Mr Shaughnessy, a specialist in medical legal affairs, is now doing postgraduate work at the University of Toronto, studying law.

His recent major contributions included, *The Child as Target*, an examination of the literature suggesting there might be a link between alcoholism and child abuse. In March, he reported on the World Health Organizations's new policy and program in the prevention and treatment of drug dependence.

In future, he'll be looking more closely at some of the civil rights issues in this field of alcohol and drug dependence.

Where a science editor checks it all . . .

ACCURACY is a goal of any publication, but for readers of **The Journal** it is vital scientific data are presented clearly and concisely. To maintain this important objective, **The Journal**, in September, 1976, appointed a Science Editor to check all articles before publication.

Ruth Segal is acting joint head of the Narcotic Dependence Program at the Addiction Research Foundation of Ontario, an assistant professor at the University of Toronto, and a research scientist at the ARF. She also holds a senior post within the ARF's Core-Shell Treatment Research System.

Dr Segal's articles have appeared in the *Journal of the American Pharmaceutical Association*, the *Canadian Journal of Public Health*, and the *Bulletin of the Ontario College of Pharmacy*, among others.

In addition, her papers have been presented at such conferences as the International Congress on Clinical Chemistry, the National Drug Abuse Conference, and the meeting on Biomedical Research in Narcotic Abuse Problems, held by the Canadian Non-Medical Use of Drugs Directorate.

Dr Segal received her PhD in pharmacy administration from Purdue University, and joined the ARF in 1970.

Ruth Segal

New Books

by RON HALL

Stalking the Large Green Grant: A Fund Raising Manual For Youth Serving Agencies

. . . by Ingrid Utech

This second edition provides information on how to raise funds, where to seek funds, and how to influence funding decisions. Descriptions of additional federal programs related to assisting youth are provided and addresses of many federal agencies which can be contacted for additional information listed. Included in this volume is information for those seeking funding for programs in the area of the use and abuse of alcohol and other drugs.

(National Youth Alternatives Project, 1830 Connecticut Ave, NW, Washington, DC, 20036. 1976. 80p. $5.)

On Becoming A Counselor: A Basic Guide For Non-Professional Counselors

. . . by Eugene Kennedy

This book has been written for individuals who, without extensive psychological training, must deal with troubled people as part of their work. A few of the areas of counselling which are covered are: alcoholism and drug dependence, depression, suicide, and anxiety. The meaning and symptoms of true emergencies are explored as are the aspects of interviewing, diagnosis, referral, and emotional involvement.

(The Seabury Press, 815 Second Ave, New York, NY, 10017. 1977. 347p. $12.95.)

Other Books

Cellular Basis of Behavior — Kandal, Eric R. W. H. Freeman and Company, San Francisco, 1976. "An introduction to behavioral neurobiology." Bibliography, index. 727p. $19.95.

Biofeedback and Self-Control 1975/76 — Barber, T.X., DiCara, Leo V., Kamiya, Joe, Miller, Neal E., Shapiro, David, and Stoyva, Johann (eds). Aldine Publishing Company, Chicago, 1976. Indexes. 518p.

Kids and Alcohol, The Deadliest Drug — Englebart, Stanley L. Lothrop, Lee and Shepard Company, New York, 1975. References, index. 64p. $4.59.

The Whole College Catalog About Drinking — Hewitt, Keith. National Institute on Alcohol Abuse and Alcoholism, Rockville, 1976. "A guide to alcohol abuse prevention." Appendexes. 129p. $5.

China From The Opium Wars to the 1911 Revolution — Chesneaux, Jean, Bastid, Marianne, and Begere, Marie-Claire. Pantheon Books, New York, 1976. Maps, glossary, index. 412 p. $8.25.

Drugs and Drug Dependence — Edwards, Griffith, Russell, M.A.H., Hawks, David, and MacCafferty, Maxine (eds). D. C. Heath and Company, Lexington, 1976. Epidemiological studies, treatment populations and treatment organizations. References, bibliography, index. 252p. $17.50.

Program Evaluation: Alcohol, Drug Abuse, and Mental Health Services — Zusman, Jack, and Wurster, Cecil R. (eds). D. C. Heath and Company, Toronto, 1975. Theory and overview, evaluation in practice, evaluation techniques, critical issues. 280p. $14.

Junkies and Straights: the Camarillo Experience — Coombs, Robert H. (ed). D. C. Heath and Company, Toronto, 1975. Addicts, professionals, and the public; treatment, community, research. Indexes. 254 p. $16.

Cocaine Consumer's Handbook — Lee, David. And/Or Press, Berkeley, 1976. Cocaine and health, cocaine trade, tests, appendexes. 54 p. $4.95.

Pharmacology: Drugs Affecting Behavior — Kornetsky, Conan. John Wiley and Sons, New York 1976. Basic principles, placebo effect, neurophsyiology, narcotic analgesics, hypnotics and sedatives, alcohol, amphetamines, nonmedical use of drugs. 275p. $20.30.

Psychopharmalogical Agents. Volume IV: Use, Misuse, and Abuse — Gordon, Maxwell (ed.) Academic Press, New York, 1976. Perspectives, nonabusive analgesics, psychotomimetic agents, methadone maintenance, regulatory aspects. 215p. $25.30.

What's In A Mushroom — Norland, Richard Hans. Pear Tree Publications, Ashland, 1976. Part III — psychoactive mushrooms, history, identification, species, chemistry, tests. Bibliography, index. 125p. $4.95.

Hallucinogenic Plants Of North America — Ott, Jonathon. Wingbow Press, Berkeley, 1976. Bibliography, index. 162 p. $6.

Sinsemilla: Marijuana Flowers — Richardson, Jim. And/Or Press, Berkeley, 1976. 95p. $9.95.

Alcohol: The Crutch That Cripples — Hafen, Brent Q. West Publishing Company, St. Paul, 1977. Effects on the body, behavior, social problems, treatment, prevention, legal aspects. Bibliography, index. 224p.

Cancer group starts its drive

LOS ANGELES — The American Cancer Society has begun a five-year drive to stop government tobacco subsidies and to increase the regulation of sales and promotion of cigarettes.

"We believe this program will save 70,000 lives a year," said Allan K. Jonas, chairman of the society's tobacco and cancer committee.

"Approximately 50 million Americans are hooked on the weed. Many of them are young people."

The problem of smoking among the young has become so serious the organization's educational program will now extend down to the third grade.

"In the next five years we want to ban all cigarettes which do not contain 50% less of the harmful ingredients than the year before," Mr Jonas said.

That means 50% less tar and nicotine than they contained the previous year.

"We would like to phase out the government tobacco subsidy," he said.

"The Government is packed with regional interest, but we think we can outvote the tobacco interests."

New Brunswick breaks a record

FREDERICTON — Consumption and availability of alcoholic beverages hit record levels in the fiscal year ended March 31, 1976, it was revealed in the New Brunswick Legislature in early March.

Finance Minister Lawrence Garvie reported the former New Brunswick Liquor Commission (since replaced by the NB Liquor Corporation) realized total sales of $9,957,933, with gross revenues reaching $96.57 million.

At the end of the year, the number of licences in effect was 642. The population of New Brunswick is approximately 670,000. In addition, the Commission had 65 retail stores in operation.

The figures reveal the pattern of the past dozen or so years has been maintained, with consumption in the province rising steadily.

The gross revenues of $96.57 million were up $14.49 million, or 17.7%, over the previous year.

The major portion of consumption took place in the home, with sales of $79,427,595 through government stores. Licence sales accounted for $15,530,338 through clubs, taverns, restaurants, etc.

Although liquor sales were in front where purchases through government stores were concerned, in the overall picture beer held a narrow lead as the favorite alcoholic beverage of New Brunswickers. Beer sales totalled $44.57 million, liquor $42.74 million, with wine trailing at $7.63 million.

Net profits were down marginally in terms of the percentage of total revenue, representing 34.6% compared to 36.5% in 1974-75. But net profits overall were up to $33.42 million from $29.44 million — an advance of 13.5%.

Reports to the Legislature regarding various departments' accounts traditionally are a year or more out of date. It is highly probable that despite inflation and rising unemployment, the province sometime in late fiscal 1976-77 crossed the $100,000,000 mark for the first time ever.

Toronto's alcoholism deaths up

TORONTO — Deaths in Toronto from cirrhosis of the liver are being increasingly linked to alcoholism.

In 1976, alcoholism was a contributing factor in 64.5% of deaths from cirrhosis of the liver, an increase of about 4% over 1975 figures and twice what it was seven years ago.

In a preliminary report on medical statistics, Dr G. W. O. Moss, Toronto's medical officer of health, said cirrhosis of the liver was the eighth leading cause of the 7,735 reported deaths last year.

"It represented 2.2% of all deaths, as it did in 1975, but more cases are related to alcoholism."

Cancer and heart diseases were the major causes of death in the city, accounting for more than 50% of the total fatalities.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

1st International Congress on Toxicology — March 30-April 2, 1977, Toronto, Ontario. Information: Robert G. Burford, G. D. Searle and Company of Canada Ltd, 400 Iroquois Shore Rd, Oakville, Ont.

Total Health '77 — April 9-11, 1977, Toronto, Ontario. Information: Gavin Collier, (416) 484-1871 or (416) 869-0831.

INPUT 77: 2nd National Conference on Occupational Alcholism and Drug Abuse — May 1-4, 1977, Ottawa, Ontario. Information: Phyllis Buirds, Humber College, Conferences and Seminars, Centre for Continuous Learning, PO Box 1900, Rexdale, Ont., M9W 5L7.

Solvents, Adhesives and Aerosols — May 11, 1977, Toronto, Ontario. Information: M. Miller, Industry Branch, Ministry of Industry and Tourism, 900 Bay St, Queen's Park, Toronto, Ont, M7A 2E2.

The Chemically Dependent Woman: Recognition, Referral, Rehabilitation — June 4, 1977, Toronto, Ontario. Information: Heather Rowe, The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 32I.

The Canadian Medical Association and Quebec Division Annual Meeting — June 19-24, 1977, Quebec City, Quebec.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections 1977, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference FUTURACTION — July 10-15, 1977. Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

Institute on Addiction Studies — August 14-19, 1977, McMaster University, Hamilton, Ontario. Information: Alchol and Drug Concerns Inc, 15 Gervais Dr, Suite 603, Don Mills, Ont, M3C 1YB.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference Headquarters, c/o The Portage Institute, 3418 Drummond St, Montreal, PQ.

1977 World Congress on Mental Health — Aug 21-26, 1977, Vancouver, British Columbia. Information: Secretariat, World Federation for Mental Health, 2255 Wesbrook Mall, University of British Columbia, Vancouver, BC, V6T 1W5.

US

National Association of Black Social Workers 9th Annual Conference — April 6-9, 1977, New Orleans, Louisiana. Information: Family Service Association of America, 44 East 23rd St, New York, NY, 10010.

American Orthopsychiatric Association 54th Annual Meeting — April 13-16, 1977, New York City. Information: The American Orthopsychiatric Association Inc, 1775 Broadway, New York, NY, 10019.

International Conference on Alcoholism in Multi-National Operations — April 28-29, 1977, Boston, Massachusetts. Information: J Wayne Fulford, The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ontario, M4G 3Z1.

National Council on Alcoholism-American Medical Society on Alcoholism 8th Annual Medical-Scientific Meeting — May 2-4, 1977, San Diego, California. Information: Frank A. Seixas, National Council on Alcoholism, 733 Third Ave, New York, NY, 10017.

Industrial Training Seminar on Effective Methods for Helping the Alcohol and Drug Dependent Employee — May 4, 1977, Lionville, Pennsylvania. Information: Bob Forman, Malvern Institute, PO Box 297, Malvern, PA, 19355.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

Conference of the Commonwealth Prevention Alliance — May 25-27, 1977, Tamiment, Pennsylvania. Information: Phyllis Hirschfield, COMHAR, 107 East Lehigh Ave, Philadelphia, PA.

American Medical Association Annual Meeting — June 18-23, 1977, San Francisco, California. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illinois, 60610.

1977 New England School of Alcohol Studies — June 19-24, 1977, Colby College, Maine. Information: Jan Swift Durand, coordinator, PO Box 11009, Newington, CT, 06111.

6th Ohio Drug Studies Institute — June 21-24, 1977, Westerville, Ohio. Information: Jim Shulman, Ohio Bureau of Drug Abuse, State Office Tower, 30 East Broad St, Room 1352 A, Columbus, Ohio, 43215.

35th Annual Session of the Summer School of Alcohol Studies — June 26-July 15, 1977, Rutgers University, New Brunswick, NJ, 08903.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Centre, McLean Hospital, 115 Mill St, Belmont, Mass, 02178.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking" — July 27-29, 1977, Seattle, Washington. Information: Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, Seattle, Wash 98195.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977. Honolulu, Hawaii, Information: Rosa Torres, Congress coordinator, 6th World Congress of Psychiatry, 1700 18th St. NW, Washington, DC, 20009.

1st International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation Inc, 222 E Redwood St, Baltimore, MD, 21202.

Alcohol and Drug Problems Association of North America Annual Meeting — Sept 25-29, 1977, Detroit, Michigan. Information: ADPA, 1101 Fifteenth St, NW, Suite 204, Washington, DC, 20005.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultant on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, Ariz, 85010.

Abroad

95th and 96th Sessions of the Permanent Technical Committee — May 9-13, 1977, Customs Cooperation Council Headquarters, Brussels, Belgium. Information: Customs Cooperation Council, 40 rue Washington, Brussels, Belgium.

20th Session of the International Narcotics Control Board — May 12-27, 1977, Geneva, Switzerland. Information: Secretariat of the INCB, United Nations Office at Geneva.

6th International Conference of the World Union of Organizations for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28 Place Saint Georges, F-75442, Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

4th Institute on Drugs, Crime and Justice in England — July 3-24, 1977, University of London. Information: Arnold S. Trebach, director, Institute on Drugs, Crime and Justice in England, Center for the Administration of Justice, The American University, Washington, DC, 20016.

Dilemmas in Treatment — July 24-29, 1977, Venice Italy. Information: Clara Shapiro, conference coordinator, Center for Policy Research, 475 Riverside Drive, New York, NY, 10027.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977, Tokyo and Kyoto, Japan, Information: ICAA, Case Postale, 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28-Sept 1, 1977, Bergen, Norway. Information: Peter Nathan, department of Psychology, Rutgers University, New Brunswick, New Jersey.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

US drinking at 38-year high

PRINCETON, New Jersey — Drinking in the US has reached a 38-year high and the proportion of families where liquor is cited as the cause of trouble has increased dramatically in the past three years, according to the latest audit.

Seventy-one percent of Americans 18 years and older, drink liquor, beer, or wine and only 29% consider themselves abstainers.

Only three years ago drinkers accounted for 68% of the population.

The rise has occurred almost entirely among women. While the proportion of male drinkers has remained about the same level, the proportion of female drinkers is up five percentage points. Men, however, continue to be more likely to drink than women.

The question asked to determine the incidence of alcohol usage was: "Do you have occasion to use alcoholic beverages such as liquor, wine, or beer or are you a total abstainer?"

A breakdown of the figures shows that 77% of American men drink compared with 66% of women.

The incidence of drinking increases with education.

Eighty-two per cent of those who drink have attended college, 71% attended high school, and 46% attended only grade school.

Those in the east had the highest percentage (79%) followed by the west (77%) midwest (74%) and south (57%).

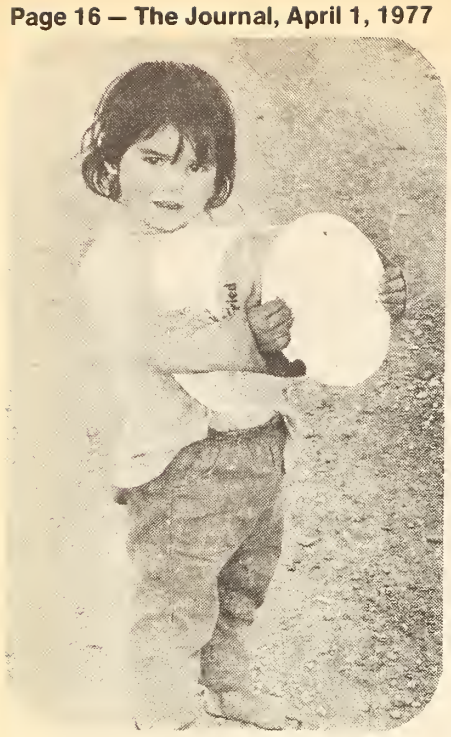
Catholics outranked Protestants 84% to 81%.

According to age, 78% of the 18- to 29-year-old group drink, 77% of the 30- to 49-year old group and 77% of those 50 years and older drink.

Eighteen percent of Americans say alcohol has been a cause of trouble in their families. In 1974 the comparable figure was 12% — the same recorded in a survey in 1966.

The survey shows one person in five (19%) favors a return to prohibition. A decade ago, the figure was 22%; 20 years ago it was 28%.

Positions Available



Alcohol abuse is a symptom of a much deeper ill, say Indian politicians in the Northwest Territories — the lack of power to control their own lives. At this General Assembly in Fort Norman in 1976, the issues of power, leadership, land claims, and political destiny were discussed (above). Indian children of the Northwest Territories (left and right).

'Like a brush fire in a boreal forest'

Prohibition is sweeping northern frontier

By Nancy Cooper

PROHIBITION died of failure 40 years ago in southern Canada, but in Canada's stark Arctic, Indians and Eskimos are turning to prohibition and severe rationing as the last hope for a liquor-ravaged land.

A recent change in the liquor laws in the vast Northwest Territories has made it possible for the first time for each settlement to set its own liquor policy. And like a brush fire in a boreal forest, prohibition and rationing is sweeping across the north.

In the Dogrib Indian settlement of Rae-Edzo, near the NWT capital of Yellowknife, the 1,400 inhabitants voted to make their community the only place in Canada where it is now an offence to have liquor anywhere at any time. In Frobisher Bay on Baffin Island, a desperate petition from 300 citizens prompted the sudden closure of the government liquor store. The store was aptly turned into a museum. In Fort Resolution, drinkers are rationed to a few bottles of booze a month. By mid-1977, 15 communities across the Arctic and along the Mackenzie River will have voted by secret ballot whether to ban or ration the demon drink.

Genocide by alcohol

That northern aboriginal races are shouldering a massive problem is indisputable. One drug abuse expert calls the situation genocide by alcohol; even the most conservative observers concede there is a crisis of epidemic scale. Acute intoxication and its side effects — shootings, beatings, malnutrition, child neglect, and family breakdown — are familiar themes "up north". Even the sleepiest hamlet explodes with liquor tragedy — a stabbing in Snowdrift (population 262); drownings in Norman Wells (population 353); a multiple murder in Aklavik (population 700). Every winter victims stupefied by liquor wander obliviously to a frozen death at 40 below.

"If we had systematically set out to destroy a society, or a series of societies, we could not have done a better job," says Donald Bruce, former director of the abuse program in the NWT.

Those in the frontier territory drink more liquor, per capita, than in any province in Canada. At an annual consumption rate of 4.34 gallons of alcohol per person, NWT drinkers are out-guzzled only by Yukoners, who consumed an average of 4.5 gals. in 1974. (By comparison, Ontario's per capita rate was only 2.4 gallons; New Brunswick's 1.78.)

And northerners suffer heavily in human terms for their swashbuckling image. Liquor and violence is the number one cause of death in the NWT. Death by cirrhosis of the liver is twice the rate of British Columbia, which in turn has the highest rate in southern Canada. Murder statistics in the NWT are nine times worse than the national average. Assaults are 10 times more frequent than nationally, and rape is seven times as common. Almost all crime occurs when liquor is present (81% of the people sentenced to jail in 1974 committed crimes after drinking).

The Royal Canadian Mounted Police, who police the north, say that in one year 6,400 people, or a third of the entire adult population of the Territory, were held overnight in cells because of drunkenness. And almost all inmates serving time in the NWT jails are native people — 84% in 1974.

(NWT population figures: 16,000 Inuit; 20,000 Indians and Metis; 9,000 white.)

Despite these disturbing statistics, the territorial government, a colonial-style arm of the federal government with few real powers of its own, appeared outwardly passive. While the consumption and abuse figures spiralled, the NWT liquor system was busy appointing a wine-tasting committee to import better wines for northerners. Advertising campaigns and the few over-burdened detox centres were doing little to change attitudes to alcohol use. The government's uniform liquor pricing policy, where a bottle of beer costs the same in Yellowknife as in the isolated community of Cambridge Bay, was interpreted as a form of liquor subsidization and looked bad when stacked against essentials like food and fuel and shelter which cost much more in isolated areas than in northern urban centres.

Maybe the government was not really serious about combatting liquor abuse, Mr Bruce suggested pessimistically.

Profit on liquor sales

"Without alcohol freely available, the need for the majority of 'people services' would be reduced substantially," he told the NWT Council last year. "This would be accompanied by the potential loss of profits in the private sector as well as some jobs. In addition, governments are the major recipients of revenue derived from the sale of alcohol products." Although liquor sales tax provides the NWT with its second largest revenue source ($4.4 million profit this year), the costs in handling problems created by liquor misuse is twice that amount, Mr Bruce estimated.

When Mr Bruce suggested a year ago that outright prohibition might be a viable option for the NWT, he was echoing the words of many community leaders and Indian band chiefs. Maybe prohibition or strict rationing was the only short-term solution for a people unable to cope. Drinking had become an outlet for a people who were struggling to emerge from the stone age to the space age in one generation.

One point in favor of even considering prohibition was that although liquor overuse has been violent and extreme, it has also been recent. The Inuit had their first contact with manufactured liquor when the white whalers arrived in Arctic waters with kegs aboard. Fur traders used liquor for trade with the Indian trappers. Although homebrew appeared at feasts and celebrations, it is only in the past 15 years that northern natives seriously adopted alcohol. In the 1950s, liquor outlets began serving white customers who were invading the north in increasing numbers, but it was not until the late 1950s during a flush of concern for civil liberty, that natives in the north were allowed to drink.

And if there is any place where prohibition could work, it would be in Canada's north, where most settlements are accessible only by air and where everyone knows everyone and their business.

People drink quietly

No one is predicting that banning or rationing alcohol will solve the liquor problem forever, but initial results are impressing even the skeptics.

In Rae-Edzo, the major Indian community and the first to ban liquor outright, the RCMP report that they have had hardly a call in two weeks, and parishioners tell the local priest that for the first time in years they can sleep in peace, knowing their doors won't be smashed or their windows broken by midnight revellers. Booze is still getting into the community, but people are drinking quietly in their homes and drinking less, the RCMP say.

Elizabeth Mackenzie, a respected Indian elder and Justice of the Peace in Rae-Edzo, sentenced a man caught drinking to a stiff fine and a week of washing dishes at the local student lunchroom. She is discouraged however, that there is any drinking in her community at all, and says things weren't like that in the old days.

Many whites are against the prohibition. Welfare worker Marge Sakundiak thinks it is creating a greater dependency among the Dogrib people. "I feel it should be an individual responsibility, that prohibition puts the onus on the RCMP and other service delivery systems to hold the people off booze." However, she admits violence has dropped, and that prohibition's strength is that it was a community decision.

"I can't help but be in favor even though it's punishing me," says Metis Territorial councillor Richard Whitford from Rae-Edzo. He's been stopped three times by RCMP and had his truck searched and openly admits he drives to Yellowknife when he feels like "getting drunked up". "Nobody will know the end result of this prohibition until this winter's out," he adds. He thinks a couple of car accident deaths or freezings on the bleak 80-mile stretch of highway linking his village to the Yellowknife bars could turn people against prohibition.

It is in Frobisher Bay, on Baffin Island, that the effects have been most dramatic. There are no roads out of Frobisher Bay and when the government liquor store was closed on May 1, 1976 in response to a petition by 300 of the town's 2,500 citizens, the effect was almost immediate.

The town's three bars remain open, but drinkers wanting to imbibe at home are now required to apply for a special import permit to order their liquor from Montreal, a process that can take up to three months.

Visitors to Frobisher Bay return astounded by the change in the community that had earned the worst reputation in the north. RCMP Staff Sergeant Dick Vitt, originally a skeptic, says that every liquor-related crime in the book has dropped off dramatically. The drunk tank is virtually empty now, and the Baffin Region Correctional Centre, usually overflowing with Frobisher prisoners, is half empty.

RCMP figures show that after the liquor store closed, criminal offences dropped by 50% immediately, and liquor offences dropped from 373 for three months in 1975 to only 76 for the same period in 1976. Hospital admissions are down, court dockets markedly lighter and municipal and recreational affairs better attended.

"Quite amazing" is how Frobisher high school principal Lynn Nash characterizes the improvement in his students. School

(continued on page 12)

A traditional native gambling game in progress — the drummers beat out a steady rhythm while the players attract a crowd of spectators. All photos (except upper left) by Nancy Cooper.

THE BACK PAGE

The Journal

Vol. 6 No. 5 2nd Class Mail Reg. No. 2776 **Published monthly by Addiction Research Foundation of Ontario** TORONTO May 1, 1977

US is divided on question of scarlet poppy

By Harvey McConnell

WASHINGTON — American domestic cultivation of the scarlet poppy, *Papaver bracteatum*, should be allowed to go ahead, an administrative law judge has recommended after a three-day public hearing.

Judge Francis Young said the Drug Enforcement Administration should consider adopting modifications to the proposal made at the hearing and that the proposal be promulgated. His report has gone to Peter Bensinger, DEA director.

The scarlet poppy is a rich source of thebaine which can be converted into powerful narcotic compounds, including codeine. The proposal to cultivate it commercially in the US was revealed in **The Journal** (January) and since then has drawn criticism from around the world.

Implacable opposition to the proposal was expressed at the hearing by Robert DuPont, speaking for the National Institute on Drug Abuse which he directs, and Mathea Falco, senior advisor to the Secretary of State and coordinator for international narcotic matters.

Pharmaceutical company representatives reiterated claims — which prompted the original proposal to grow the scarlet poppy — that America needs a sure and dependable supply of codeine.

The spectre was raised also of a possible thebaine shortage, which one pharmaceutical company spokesman said has now assumed "a new prominence in medical practice."

It was disclosed that several

(See — Cultivation — page 3)

Health Minister Lalonde reveals

Narcotic Control Act may be changed

By Bryne Carruthers

OTTAWA — The federal government may decide to repeal the controversial Part II of the Narcotic Control Act that would have allowed courts to sentence drug addicts to mandatory treatment had the section ever been proclaimed into law.

Marc Lalonde

In an exclusive interview with **The Journal**, Health Minister Marc Lalonde revealed he is considering replacing Part II of the Narcotic Control Act with new legislation to give courts more flexibility with respect to treatment of drug users.

He said new treatment provisions might even be included in the long-awaited cannabis legislation which would move cannabis crimes from the Narcotic Control Act to the less-stringent Food and Drugs Act.

The cannabis changes, which would involve modification to the Narcotic Control Act, won't likely be reintroduced in Parliament until the fall, and only if the government is certain the Bill will finally be approved.

Mr Lalonde said Part II was never proclaimed and more recently it has become increasingly evident it could never be proclaimed into law.

He explained recent experiences with treatment of alcohol and drugs users have convinced federal experts the provisions contained in Part II are outmoded.

The Minister wouldn't say more about what new measures might be introduced into law on treatment, though he did say he will be taking to cabinet in the near future a set of proposals on the prevention and cure aspects of "hard drugs," such as heroin, that were provided him by the British Columbia government and BC drug enforcement organizations.

He said as a result of some of the proposals from BC, the government in Ottawa might decide to make changes under the Criminal Code and under customs procedures designed to assist law enforcement officials on the west coast to fight opiate crimes, including heroin importation.

The BC proposals, Mr Lalonde said, relate to prevention and cure of drug problems, as well as tightening of law enforcement, and would be reviewed by Ottawa in that context.

The unproclaimed Part II of the Narcotic Control Act which could be finally eliminated by Ottawa is entitled "Preventive detention and custody for treatment."

Under Part II, people convicted of trafficking or importing a

(See — Treatment — page 5)

Between 15 and 20 countries share the dubious distinction of having the most serious drug-related problems in the world, according to a report by the International Narcotics Control Board. See The Back Page.

BC enlists feds for war on heroin

By Tim Padmore

VANCOUVER — New initiatives to battle the heroin problem here seem imminent.

A joint federal-provincial committee with a crash schedule to come up with solutions has been appointed, and health minister Robert McClelland promised to put a comprehensive provincial plan before the cabinet in April.

Justice minister Ron Basford and British Columbia attorney-general Garde Gardom, in an impressive display of federal-provincial co-operation, announced they had given a six-member panel until the end of May to recommend methods of combatting heroin abuse in Canada, with particular reference to BC, which has about half of Canada's estimated 19,000 heroin addicts.

Mr McClelland says after he gets cabinet approval for his plan, he will forward it to the intergovernmental panel. The result of the panel's work may be a pilot project of some sort in BC, although he conceded it is hard to start a project in just one province as addicts might simply move on to another.

He made it clear BC is not considering any easing of heroin laws, such as a move to the British system where heroin addicts

(See — Heroin — page 5)

In a special report, Dr Eva Tongue, assistant director of the International Council of Alcohol and Addictions, describes the steps being taken in the Soviet Union in the wake of alarming increases of alcohol use. See page 6.

Alcoholism underestimated in UK

By Alan Massam

LONDON — As field workers have frequently asserted, British government calculations of the size of the problem of alcoholism here, are likely to be serious underestimates.

This opinion has been published by the most reliable of authorities — the government's own Office of Population Censuses and Surveys. Two researchers from the OPCS's Medical Statistics Division, Stuart Donnan and John Haskey, note that using the formula of Jellinek (based on deaths from cirrhosis of the liver in alcoholics and the general population), a World Health Organization subcommittee estimated there were 86,000 alcoholics with complications in England and Wales in 1948.

At that time in the United States, it was estimated that of every four alcoholics only one had complications which brought them into hospital. On that basis, the total number of alcoholics in England and Wales was estimated to be 4 x 86,000, that is approximately 350,000.

The OPCS researchers go on: "The WHO considered that deaths from cirrhosis of the liver were the 'least satisfactory' index of the extent of alcoholism and that the estimate of total alcoholics of 350,000 was 'hardly better than a guess'.

"The recently published department of health and social security estimate is that as many as 500,000 people in England and Wales may have a serious drink problem. This figure was based on Jellinek's original estimate with an allowance for the increase in mortality related to alcoholism over the past 30 years."

Dr Donnan and Mr Haskey report that using the annual death rates of alcoholics for various causes of death, and the total number of deaths (using the method of Schmidt and de Lint) they estimate that 235,000 deaths could be attributed to alcoholism in England and Wales in 1973.

Their alternative estimate based on deaths attributed to alcoholic cirrhosis of the liver was 155,000, which, multiplied by four gave about 600,000 as the total number of alcoholics. But adjusting this figure for the known underdiagnosis of alcoholism by family physicians showed that the total in 1973 might have been as high as 740,000.

The authors' conclusion is that the DHSS estimate of half a million alcoholics in England and Wales can only be regarded as a *minimum.*

Operation Yellow Jacket, a pilot program backed by the United States government to get rid of the drunk driver on Maryland's highways, will be offered to other state police forces if deemed succesful. See page 4.

Serum hepatitis drug promising

TORONTO — A vaccine against serum hepatitis (Type B hepatitis) is now undergoing clinical testing in the United States and France.

First reports indicate it is doing extremely well in protecting high-risk personnel. And it may in fact be the first anti-cancer vaccine (see page 5).

Saul Krugman, professor and chairman of the department of pediatrics at New York University School of Medicine, and a pioneer in hepatitis research, gave this encouraging news to a meeting of pathologists here.

Dr Krugman told the American Association of Pathologists that his French colleague Dr Philippe Maupas of Tours, France, is working with artificial kidney personnel because they are traditionally at high risk of catching Type B hepatitis. (Many kidney patients have had exposure to Type B hepatitis through blood transfusions and exposure to contaminated hardware. Nursing and laboratory staff also have a high attack rate as they are handling the same materials.)

Last year Dr Maupas published work in *The Lancet* (June 26, 1976) in which he said no cases of hepatitis had appeared in either patients or staff protected by the prototype vaccine. In control patients, the attack rate was 43% and 19% in staff.

Dr Krugman said the French

(See — Hepatitis — page 5)

Regular features

Special nurse teams make treatment affordable

WEST COVINA, Cal. — Virtually all services at five substance abuse clinics in this area sprawling out from Los Angeles are being provided by four highly trained nurse practitioners.

"I can't begin to tell you what it has allowed us to do," says Forest Tennant, a public health physician who established the clinics, devised the programs, trains the nurses, and provides backup supervision.

Only in cases of clear medical need does Dr Tennant step in.

The experience over the last two years leaves him in no doubt that the nurse practitioner is the only answer for provision of adequate services in many areas of the country, on both practical and economic grounds.

Dr Tennant explains: "We run our methadone maintenance clinics, for example, at a cost of $1,200 a patient per year. This is the lowest figure I know of anywhere.

"In Los Angeles County, for example, the figure runs between $3,000 and $4,000 a patient per year."

Dr Tennant set up the clinics in this part of the San Gabriel Valley to serve the underprivileged "and the working poor: they are not on the poverty level but they don't make enough to afford a private physician."

Fees are high for patients lucky enough to find a private physician. "We have areas here in this valley where we are really short of physicians," he adds.

To provide the services he felt were necessary, Dr Tennant decided to train his nurse practitioners so well "that now they can literally do 80% of what a general practitioner can do.

"They run the heroin detoxication programs, the methadone maintenance programs, and do physical examinations and counselling."

The nurses, in turn, have backup teams of medical assistants and aides. Dr Tennant has set protocols where he intervenes.

"For example, if they get an addict who is seriously debilitated with a pulmonary infection they will call me. Then it is more a question of clinical medicine than alcohol or drugs."

The nurse practitioners, who see an average of 200 patients a week, do not stop there. Although their main concern is substance abuse, they run mobile clinics in such areas as contraception, general medical care, senior citizen care, and well-baby clinics.

In addition to the five outpatient clinics, Dr Tennant and his team perform medical care for 12 halfway houses for alcoholics and drug users.

He says: "This has allowed the ex-addicts and ex-alcoholics who run the recovery houses finally to have some medical backup. Before us they didn't have anything.

"The houses for drug abusers, for example, didn't meet the NIDA (National Institute on Drug Abuse) standards and they just could not get funding because they had no medical support. Now they have."

Dr Tennant is able to call on medical backup from colleagues in nearby universities.

The nurse practitioners have erased some myths as well. The fact they are not doctors means nothing to the patients. "What we have found time and time again is that people respond to expertise, period."

Dr Tennant says they have also "shattered some myths about the ex-alcoholic or the ex-addict being such a hot counsellor too."

The idea of the nurse taking over many of the sacred roles of the doctor has not proved as explosive to Dr Tennant's colleagues as he thought it might.

"Maybe there were some grumbles initially, but the private physicians in this area are very supportive and very helpful. After all, we see the kind of patients they don't want to handle.

"On top of that, once we find a difficult case we send it to them, and it actually builds their business. So they have come to support us to a great extent."

What Dr Tennant would like to see now is more recognition generally for the nurses.

He points out: "In the drug abuse field, the nurse practitioner has not received any sort of status. This is very unfortunate because drug abuse is a field in which you are dealing with very poor people and there is a very limited amount of government money to go around.

"But at least here, and for the first time, I can confidently say we are starting to deliver a wide range of services of some reasonable quality. The nurse practitioner has made this possible.

"She has allowed us finally to bring the cost of services down to a price the public and government can afford."

Liquor, beer, played down

BC govt encouraging wine drinking

By Tim Padmore

VICTORIA — The British Columbia government has proclaimed new liquor regulations designed to turn drinkers away from the evils of liquor and beer to the civilized virtues of Okanagan wines.

Consumer and corporate affairs minister Rafe Mair, the minister responsible for the Liquor Distribution Branch, has announced new liquor regulations that will:

- Reduce the markup on domestic wines with less than 14% alcohol from 66% to 46% and reduce the markup on imported wines from 117% to 100%.
- Allow wineries to sell their products on site and give the public free tastings of their products.
- Continue to provide local wines with a large share of shelf space in the government monopoly liquor stores and allow BC vintners to set up in-store display counters for a two-month display of new wines.

Also, a long-term education campaign to encourage moderation is planned.

"Almost all the changes we are announcing are designed to encourage a more moderate approach to alcohol consumption," Mr Mair told a press conference.

"The changes we are proposing are designed to encourage a more civilized approach to drinking by de-emphasizing the licensing of water holes and the sale and consumption of excessive amounts of liquor."

The government is not concerned about moderate drinkers, he said, and wine is a drink of moderation because "civilized drinkers usually drink it with meals."

He said it's hoped the changes will make people drink more wine and less liquor and beer.

BC winemakers, centered in the Okanagan Valley, a stronghold of the Social Credit government, are happy about the price breaks, which will cut an average 30 cents from the price of a bottle, and other concessions.

But reaction from other quarters was less enthusiastic.

Hal Moran, general manager of Molson's brewery, said the beer industry has always considered *its* products to be the drink of moderation.

"Beer is very, very commonly taken with meals," he said. "We encourage this."

Other commentators, recalling that wine-loving France has the world's highest incidence of alcoholism, wonder if the main effect of the moves won't be simply to prop up BC's discredited wine industry — one editorial writer, referring to Robert Louis Stevenson's description of California wines as "bottled poetry," said the BC product is "at best, bottled prose."

Under the new regulations, bottled prose with a cork instead of the standard screw cap will be mixed in with the imported wines, presumably in the hope that the innocent will pick up a few bottles by mistake. No new brands of cheap foreign doggerel selling for less than $2.75 a bottle will be allowed.

Mr Mair attempted to mollify oenophiles with the announcement that the provincial wine industry will be encouraged to upgrade their products. Agriculture minister Jim Hewitt is already involved with grape growers in an aggressive program of planting better quality grapes, he said.

* * *

In another move announced at the same time Mr Mair succeeded neatly in appeasing both the province's hotel owners, who have been pressing for the right to serve liquor in beer parlors, and those who have protested that that would lead to more widespread drunkenness.

His solution was to allow the hotels to change beer parlors to standards approximating those of neighborhood pubs: first-class decor, adequate furniture, a bar with seats and standup area, and seating limited to 125.

'The civilized virtues of wine for citizens of BC.'

Beer guzzlers take the cracker-jackers to bat

By Wayne Howell

LADIES AND gentlemen, the subject for tonight's debate is a topical one. I have with me on the podium Mr R. B. Higgins and Mr A. B. Crumshaw. These learned gentlemen shall address the issue: "Is beer an integral part of the game of baseball?" Mr Higgins shall speak for the affirmative and Mr Crumshaw shall elucidate for us the negative view. May we have your opening statement Mr Higgins . . . . . .

"Thank you Mr Chairman. My position is quite simply this: beer and baseball are symbiotically linked and what God has joined together no man should put asunder. And this holds true for any congress of men, such as the Ontario provincial government; to deny Toronto baseball fans their right to suds in the stands is an affront to Natural Law."

"Mr Chairman — with all due respect to Mr Higgin's opening statement, I must confess that I find it the most errant kind of nonsense; a debate is not won with sanctimonious statements, it must be based on facts. And the facts, Mr Chairman, do not support my opponent's hypothesis.

"In the first place, let us consider the traditional baseball song that has been sung or played at baseball games since time immemorial, and probably before that as well. You will notice that while the orthodox song refers to peanuts and cracker-jacks it makes no reference to malt beverages whatsoever. Now surely, if as my opponent suggests, beer and baseball really were . . . ."

"If I may interject, Mr Chairman, this is a very specious issue. That song was obviously written by someone who never went to a baseball game in his life! Cracker-jacks???? what nonsense — hotdogs, as everyone knows, is what one eats at baseball games. Just mustard, no relish."

"Mr Chairman, Mr Chairman, I am compelled to interrupt. I myself, on July 8, 1964, while watching a game at Tiger Stadium between the Tigers and the Yankees, did eat cracker-jacks. Two boxes to be exact. I would be prepared to submit the prizes as proof."

"Mr Chairman, I want to make it perfectly clear that while Mr Crumshaw and I may have our differences, I respect his integrity. It is not necessary to furnish the prizes. There are all kinds of deviants in this world and in a democratic society a man has a perfect right to eat cracker-jacks at a baseball game — although frankly I find the very thought of it repulsive. But beer is not deviant; it is an integral part of the game of baseball. A hot day at the park and a cold beer — this has been celebrated in folk legends ever since man first stood upon the shores of the new world. If you take the beer out of baseball, spurn convention, and ignore tradition, then the next thing you know baseball players will be running onto the field in drag — once you start messing around with the eternal verities of the game, the centre cannot hold."

"Come, come Mr Higgins. All this bluster and attempt at poetic expression is neither here nor there. If beer is an integral part of baseball, Mr Chairman, then perhaps Mr Higgins would be good enough to tell us why baseball games can occur in the complete absence of beer."

"If I may correct Mr Crumshaw on his facts, Mr Chairman, there is not a major league stadium in North America that does not sell beer at baseball games."

"I was speaking, Mr Chairman, before I was somewhat rudely interrupted, of minor league stadia, sandlots, and the like. Here the game of baseball proceeds without beer: this completely negates my worthy opponent's hypothesis and proves conclusively that there is no organic relationship between beer and baseball."

"Mr Chairman, I must interject. The world is not yet a perfect place and therefore there do exist small rude stadia in America where a baseball fan is denied his birthright, just as there exists sub-standard housing, inadequate educational opportunities, and discrimination against minorities. But I can assure Mr Crumshaw that baseball fans forced to view baseball in those circumstances want their beer just as much as persons who are socially or economically deprived want their rightful due. These situations are always tragic, a crime against that part of humanity that enjoys an afternoon at the ballpark, and frankly I had thought my worthy opponent was above using these lamentable situations as a means of scoring cheap debating points."

"I must protest Mr Chairman. Mr Higgins is so sanctimonious on this subject that he takes any reference I make as an attack on the Holy Trinity. Which to him, I assume, is Beer, Baseball, and Belching."

"Mr Chairman, either my opponent is being facetious or this is a feeble attempt at levity; I do not confuse this issue with the Christian religion — although I do feel quite strongly that if Our Lord had encountered the multitude at Toronto's Exhibition Stadium, he would have served them beer and hot dogs, rather than loaves and fishes."

* * *

Wayne Howell is an Ottawa physician and freelance writer.

Cults may help replace need for drugs

US team launches broad study of cult members

By Harvey McConnell

LOS ANGELES — A broad study of cults and groups to discover why young people join and whether they are subjected to psychological pressures, has been launched by California investigators.

It follows a pilot study by Thomas Underleider and David Wellisch of the University of California at Los Angeles.

Although the pilot study showed no evidence of coercive persuasion among members of an agrarian group, members of the groups did "have a high scale on psychological test batteries which are correlated with alcohol and drug dependence," according to Dr Ungerleider of the neuro-psychopathic institute at UCLA.

Certain specific needs of the individuals are being satisfied by membership of the group, he adds.

Dr Ungerleider emphasizes that the findings apply to this one group only. He and Dr Wellisch have now launched a broader study of members of as many groups, large and small, as possible, and have no idea if future findings will differ.

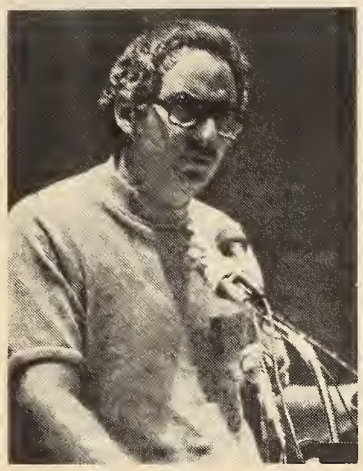
In the study, Dr Ungerleider conducts the psychiatric interviews and Dr Wellisch gives a battery of psychological tests.

Dr Ungerleider says the first study found "a number of people had been involved with drugs. And the group, with its controls and lack of drugs, provided a structure for these people which is very helpful.

"In addition, many of them have overcontrolled hostility.

"All of them are bright and there is no evidence of this thing called thought persuasion.

"All these people perceive themselves to be doing much better now than they perceived themselves before joining the group: they are more accepted and more outgoing, for example."



Thomas Ungerleider

Dr Ungerleider says the issue of group membership is very complicated.

"What is the really true suggestibility that takes many young people into these cults and groups? What needs are being satisfied?

"I know many people who have great oral dependent needs towards drugs who do well in some groups; people who have overcontrolled and unacceptable anger who do well; people who have trouble with their sexual feelings who do well in a celibate atmosphere.

"At the same time, I have heard things about some of the small and large groups that are pretty shocking and frightening. Things such as taking money from people who have worked long hours for it.

"So I am not making any kind of judgment on the groups."

Drs Ungerleider and Wellisch started their study in a small central California town where some 300 members of a group live an agrarian life and run a shop and restaurant.

"What we wanted to find were those people who were under threat from their parents of being taken away and deprogrammed. This would give us a baseline.

"If the young people were eventually deprogrammed, we could examine them afterwards to find out what trauma, if any, had been done," Dr Ungerleider adds.

'Most deprogrammers use classic brainwashing techniques.'

Just before they began, two members of the group had been taken away by Ted Patrick, a well known deprogrammer nicknamed "Black Lightning." The two later escaped.

Dr Ungerleider continues: "A judge asked us to interview these young people and see if they should be returned to their parents and given back to the deprogrammer.

"Based on the stories they told us of what had been done to them, we recommended they not be returned."

Dr Ungerleider finds that most deprogrammers "use classic brainwashing techniques: sensory deprivation, sleep deprivation, pressure, shouting, drugs for those off drugs, sex for those leading a celibate life.

"Certainly the techniques of the deprogrammers are the same as those they accuse the worst cults of using."

Some group members who have been deprogrammed, in Dr Ungerleider's experience, "have a corollary in the drug abuse field where people, once they are no longer involved with drugs, become crusaders or counsellors as a way to keep off drugs."

A phenomenon he would like to investigate at some time is the parents "because they are parents who really care about their young people.

"We have found a lot of Jewish parents, in particular, of young people we saw in one group, although by no means all, and they were very angry at them for choosing that lifestyle and not going into medicine or the law.

"These parents can't express their anger at the young people so they express their anger at the group."

Dr Ungerleider has no time for some judges who have issued temporary conservatorships against young adults, which means an effective loss of civil rights, so they can be deprogrammed.

"It seems to be that if a judge issues a temporary conservatorship without allowing the person to be notified, to have a lawyer or a doctor, or even a separate examination, then that judge is an unindicted co-conspirator in kidnapping."

He has talked to many groups of judges at the National Judicial College here. Afterwards "everyone of them who has talked to me is shocked that any judge would do this sort of thing. But it does happen."

Dr Ungerleider has found that his own professional colleagues can have extremely strong feelings on the matter.

The family physician of one young person who had been deprogrammed told Dr Ungerleider he thought, in effect, the means justifies the ends, even to the use of drugs.

The family physician asked Dr Ungerleider if he had visited the facility, and was told he had. The physician said: "Well, they have no plumbing, they had outhouses. That's it."

Dr Ungerleider, to make sure, asked the family physician if he meant the lack of plumbing and use of outhouses justified kidnapping. "Of course," was the answer.

Dr Ungerleider says that while the first study shows that in one particular group, specific needs of the young people are being satisfied, "we don't know if we can say that about all groups.

"That is important. We won't know until our research is completed."

Cultivation of scarlet poppy would taint America's image

(from page 1)

drug companies are now growing the scarlet poppy. Edco, a subsidiary of the chemical giant E.I. duPont de Nemours, has planted 700 acres overall in five American states and in Japan and Columbia, and has designed a processing plant that can start production next year in North Carolina.

A department of agriculture expert said based on the present projections, some 6,500 acres of scarlet poppies would be needed to supply the necessary amount of thebaine for conversion.

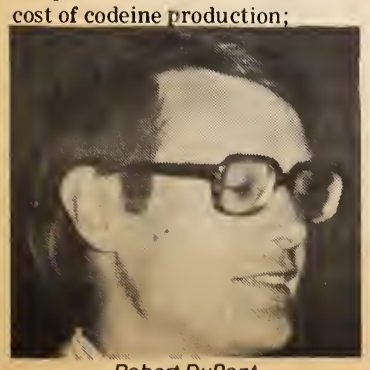
Dr DuPont told the hearing that Russia, for unknown reasons and after years of self-sufficiency, has bought unusually large quantities of opium on the international market.

The Russians "have offered no explanation for this change and we have no way of predicting their future medical needs for codeine."

He said he thought "the long-term trends in world opiate supply are for a substantial surplus. It would be difficult for me to imagine any particular country or individual entrepreneurial activity restricting that in such a way as to inflate the price, given the growing surplus."

He pointed out that four advantages would occur from domestic cultivation of the scarlet poppy:

- a stable source of natural opiates;
- American pharmaceutical companies would have a direct supply of opiates which could lower the cost of codeine production;
- a new source of supply of natural opiates would increase the overall supply available on the world market;
- the cost of medicines might be reduced.



Robert DuPont

Put against these arguments, he continued, is that "recent chemical advances have made it clear that *Papaver bracteatum* may not be safe in any absolute sense.

"The chemical conversion of its principal alkaloid, thebaine, into heroin via codeine and morphine, has been improved in the last few months, although it is still a complex and lengthy chain requiring relatively sophisticated chemical knowledge, laboratory equipment, and uncommon chemicals.

"Further questions have been raised about the abuse liability of some of these compounds along the thebaine conversion chain, because some are amazingly potent addicting substances.

"These developments were not known a few years ago."

Dr DuPont said the most important argument against the proposal is the position of America in the world community. There is now a delicate balance of global cooperation to limit at least the licit supply of opium.

The American policy of renunciation of self interest "demonstrates our commitment to global restraint by restraining our own actions."

Domestic production of the scarlet poppy could lead to a fall in the cost of illicit drugs "and a probable increase in heroin abuse in this country."

Dr DuPont went on to say that in his view, "so long as the price of codeine to American consumers does not become overly burdensome, the gains are worth the potential sacrifices. America should monitor the world supply of opium and develop a contingency plan for rapid standby domestic production should conditions ever merit such production.

Ms Falco said the department of state opposes the proposal "on the grounds such cultivation will adversely affect our efforts to work with other governments in developing a more effective international narcotics control program."

She said her discussions at the recent meeting of the International Narcotics Control Board in Geneva and private conversations with representatives from Canada, Turkey, Pakistan, and other countries, "confirmed that implementation of the Drug Enforcement Administration proposal at this time would be detrimental to our general foreign relations interest as well as to international narcotics control goals."

She said the question of morality was often raised and in private conversations what many representatives said to her was: "Look, we are trying very hard to control our own narcotics production and we just think that if you go into this production now, there is no way in the world we are going to be able to explain this back home."

Congressman Charles Rangel, from New York, told the hearing: "Now because of the laws that Congress created and because of executive orders, we find out that the very same forces that Congress created to enforce the laws against illegal trafficking also have the power to determine just how much can be manufactured and, most importantly, the medical needs of the people in this country."

Congressman Rangel continued: "I get the impression the Drug Enforcement Administration is saying they have the expertise to determine what our codeine needs would be and the derivatives from thebaine.

"They are now making medical decisions as to not only what our medical needs are but they also think it is very important that our American pharmaceutical corporations have an opportunity to take advantage of expertise. And again we have become the world leader in the manufacturer of drugs."

No-nicotine cigarettes on sale this summer

By Alan Massam

LONDON — Cigarettes containing a no-nicotine cellulose substitute for tobacco have been given the go ahead by the British department of health and social security. They will be on sale by the early summer.

The new cigarettes will contain between 20% and 40% of the cellulose substitute — known in the trade as New Smoking Material or NSM — mixed with mild tobacco.

This long-awaited go ahead for NSM follows a four-year study by a committee under R. B. Hunter of the University of Birmingham. The green light was given by the DHSS after Dr Hunter's independent committee announced they could find no evidence NSM was likely to have any adverse effects on health.

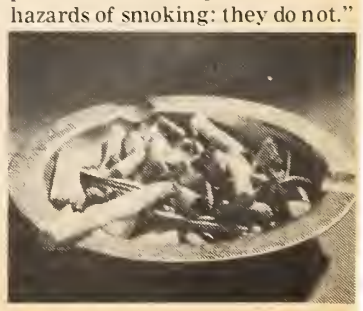
NSM cigarettes will, however, be sold with the same health warning on the packet as all-tobacco cigarettes and this situation will persist until more evidence has emerged to suggest they are, in fact, safer.

The Royal College of Physicians' anti-smoking pressure group, Action on Smoking and Health, said after the announcement of the Hunter Committee's recommendation:

"The go ahead for part substitute cigarettes . . . is a welcome step forward to less harmful smoking, but must be treated with great caution.

"There is a very real danger that media and public will talk of a 'safe' cigarette: if this happens, tobacco substitutes could do more harm than good. When cigarettes with substitute material come on the market, they will contain about 75% ordinary tobacco, and their tar and nicotine yields will be no lower than those of some brands already available.

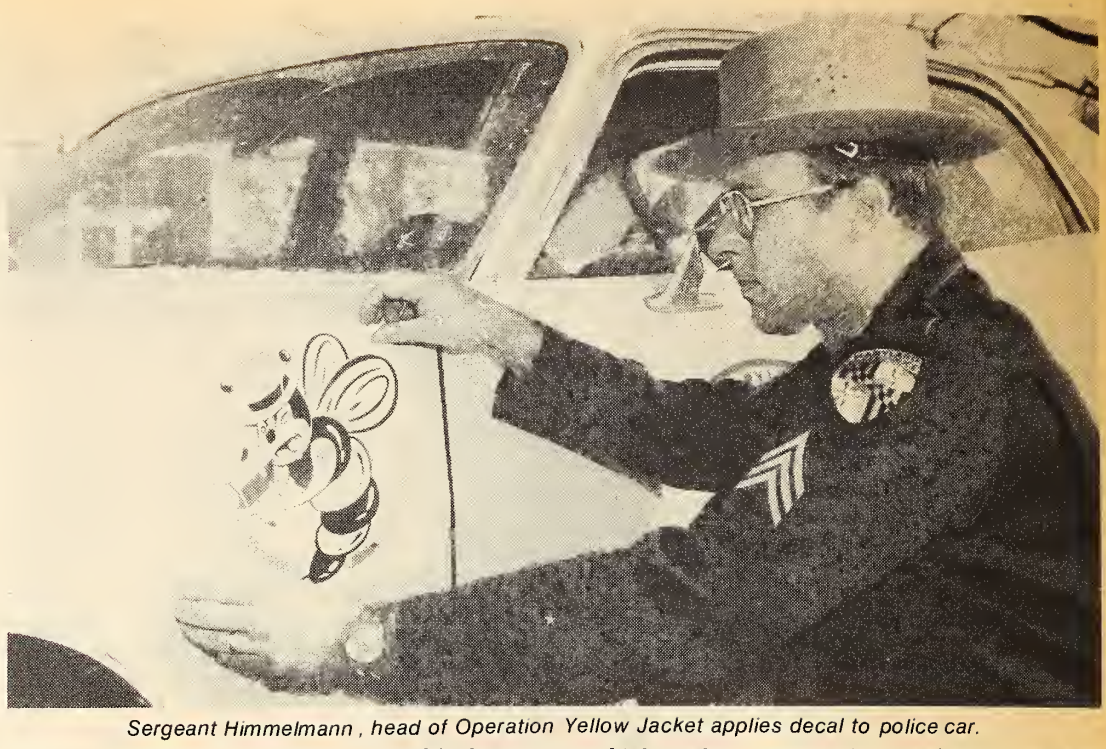
"It is to be hoped that tobacco substitutes will make low tar cigarettes more acceptable to the smoker, but no one should be deluded into imagining they provide an escape from the hazards of smoking: they do not."



No escape from hazards?

Yellow Jackets zap the drinking driver on Maryland roads

By Harvey McConnell



Sergeant Himmelmann, head of Operation Yellow Jacket applies decal to police car.

GREENBELT, Maryland — Doug Deleaver got the first one. Just. "I got him before he got me: if I hadn't hit the brakes he would have gone into my door."

Twenty minutes later, Milt Lilley, idling his patrol car in the parking lot entrance to a roadside tavern, counted out the speed as his portable radar gun scanned cars passing through a 40 mph zone: "37 .. 42 .. 46 .. I always give them eight .. 39 .. 44 .. 61!"

The radar gun hit the seat as his foot hit the accelerator. He had the speeder within 30 seconds.

It was a Tuesday night between 10 and 10.30 that the specially trained crack Maryland State Police yellow jacket team of Troopers Deleaver and Lilley made their arrests.

Both nabbed drivers were young men, both were speeding, and both were drunk.

It happened on a short stretch of Maryland Route One between Baltimore and Washington which a computer had pinpointed as a high risk alcohol-related accident zone.

Operation Yellow Jacket, which is backed by the United States government, is a one-year pilot program that if successful will be offered to other state police forces. Its specific aims are to catch drunk drivers and speeders.

Since its start in February, results have been "quite fantastic, the computer readings have been absolutely accurate," according to Sergeant John Himmelmann, leader of the four yellow jacket teams.

The first step in the operation was an analysis by a state police and US National Highway Traffic Safety Administration team, of all road accidents in Maryland over the past four years.

A computer searched every road in the state for speed and alcohol-related accidents and it found that most happened on small segments of highway, no more than five miles long. Season, day of the week, and time of day of the majority, were pinpointed.

An alcohol and speed enforcement unit was created under Sgt Himmelmann, who had previously spent three years in the Alcohol Safety Action Program (ASAP) in Baltimore county.

Sgt Himmelmann handpicked eight experienced troopers from the more than 50 who applied. The troopers were put through an intensive three week course on alcohol and related problems.

The yellow jacket teams are detached from the rest of the state police force, are assigned a different small segment of highway by Sgt Himmelmann, and work it non-stop for four hours before moving to another sector.

They answer no calls, except emergencies, and if there is a problem they bypass bureaucratic channels: through Sgt Himmelmann they go direct to Major John Blades, chief of operations.

The teams are spotted across the state and, in all, work 96 highways.

Troopers Deleaver and Lilley have a three-county area. When on patrol they are no more than 10 miles apart so each can quickly answer a call for assistance from the other.

Their main weapon against speeders is a highly sophisticated radar set mounted in the car which has a range of 5,000 feet. Their main weapon against the drinking driver is training.

Relaxing in the Greenbelt barracks before starting a four-hour night patrol, they talked about their work.

Trooper Deleaver, aged 30, worked previously with Sgt Himmelmann in the ASAP program, which is why he applied for yellow jacket duty.

Yellow Jacket decal

He said: "I don't think that I am a prosecutor, that I can judge them and say 'I don't like drunks.' I feel it is a sickness, which is why I came into the program."

"You are helping a person, really. And if we can take five or 10 habitual drinkers off the road, then the program is working and serving a purpose.

"The driver who is drinking is comparable to having a person with a loaded gun on the roads. In most of the accidents I have seen, the person who is drinking is not the person who gets hurt."

Trooper Lilley, aged 27, found the training course changed his concept of the drinking driver, and he realized how being "a nice guy" in the past had been a mistake.

He explained: "Before, I wouldn't normally arrest a drunk driver unless he had been in an accident. I would say that 50% of the time I would either drive him him, call a cab, or have someone come and pick him up.

"Now I see what the situation is, and I am aware of it. These people have a problem and my driving them home did not solve the problem.

"I realize that in that way they would just get warned, and get warned, and the more they drink the higher the chance they will have an accident and kill somebody."

The troopers have been taught some 600 signs to look for when a driver is stopped. The obvious ones are driving with the window down in cold weather, fumbling for a licence, or handing over a social security card instead.

Almost always, a drinking driver will put out a hand for support as he gets out of his car.

Trooper Deleaver finds "most of the drunk drivers think they are driving okay. When you stop them their adrenalin is flowing and they are going to try and straighten right up and present their best side.

"The funny thing is that while I find most drunks are jovial, the man who really gives you a hard time when he is drunk is really a decent guy when he is sober.

"Usually they call up the next day and want to apologize to you."

But some drunk drivers are spoiling for trouble, as Trooper Lilley found out on his first Saturday night as a yellow jacket.

The patrol cars have distinctive yellow jacket emblems as the teams court attention. A standard routine is to drive through, or stop for a time, in the parking lot of every notorious tavern on the particular stretch of highway they are patrolling.

That Saturday night, Trooper Lilley was sitting ostentatiously in the parking lot of a rowdy tavern: "It's like a family in there, everyone gets drunk and no strangers are welcome.

'The alcoholic is hardest to detect. . .if you're not really trained to look for signs they can fool you as they know all the tricks.'

"This man staggered out, didn't even see me, got in his car, and nearly hit a parked car as he tried to drive away. When I stopped him he got out and told me he knew how to box.

"I said 'okay.' Then I shouted suddenly 'hey you', and pointed behind him. As he turned to look, I put him over the hood of the car.

"You try not to fight so I put the cuffs on him. Then he started shouting for help."

That, for a lone trooper outside a tavern packed with the man's friends, is not an enviable position. But Trooper Lilley put in a call and Trooper Deleaver was with him within three minutes.

Preventive action is also effective. A member of another yellow jacket team pulled into a crowded tavern parking lot, turned on his public address system, and announced:

"I am a yellow jacket, and if anybody comes out who has been drinking and tries to get into his car, he will be arrested." For two hours the trooper sat and watched local cabs do a brisk trade.

During the day, citizen band radio operators give a warning when they spot a yellow jacket. Trooper Deleaver: "That's fine with us, we want people to know we are around."

It is the alcoholic who is hardest to detect when stopped. "If you are not really trained to look for signs they can fool you, as they know all the tricks," Trooper Deleaver said.

They often fool untrained troopers, who will hesitate and let them go. "And it happened: a trooper let a man go and no more than five minutes later we got an accident call. He had taken a pole down."

Troopers Deleaver and Lilley have a backup team of two off-duty troopers who have, in effect, a second job. They are paid by the US government, not the state. The four hours they spend on duty is not a romp. "We make them hustle," said Trooper Deleaver.

Hustle, training, and achievement is what their job is about. The two troopers do not even stop for coffee while on patrol: it takes too much time.

Ironically, on that Tuesday night, Trooper Deleaver had come in for a lot of ribbing because he was the only one of the yellow jackets yet to make an arrest for drunken driving, "although I am holding my own on speeders."

Soon after leaving Greenbelt barracks, his record changed. An unhurried "ten fifty-five, two and a half miles south" over the radio produced an immediate U-turn by Trooper Lilley. Eight miles at 90 mph, even in traffic, does not take long.

Trooper Deleaver said the driver he stopped, a visitor from Florida, shot out of a parking lot, almost hit him, drove back across the road and tried to speed away.

"You know the first thing he said to me? 'I've been partying but I am not DWI.' That makes me pretty certain he has been caught before."

While Trooper Deleaver took the driver back to barracks to have a breath test, Trooper Lilley checked several tavern parking lots before pulling up to do spot radar checks.

The driver who shot by at 61 mph was a graduate student returning from an honor society meeting. "I only had four beers," he said in a breath that penetrated the patrol car.

Breath tests showed the Florida driver had a blood alcohol concentration of 0.12% and the student one of 0.08%. Under Maryland law, a reading under 0.15% is classed as impairment and does not command a maximum sentence.

The suspected drunk driver is always given an agility test: walking a straight line and standing on one leg. The trooper does the same thing in the same place.

Trooper Lilley said: "I walk the same piece of road to see that it is not uneven, and stand on one leg in the same spot so I am able to point this out in court if asked by a defence lawyer."

Each yellow jacket ticket issued carries a special number which will later be pulled out by the motor vehicle authority so a closer investigation can be made of the driver.

Ominously, the first sign a trooper *always* look for when he walks up to a car is whether the motorist might be armed.

Troopers Deleaver and Lilley have a personal pact they hope never to have to keep.

Trooper Deleaver explained: "If I ever come upon someone holding a gun on Milt and he demands I drop mine, I won't do it because neither of us would have a chance. I just hope that if I have to shoot it will be good and Milt can get away.

"And Milt will do exactly the same thing if someone ever has a gun on me."

Meanwhile, enthusiasm and understanding are ther main weapons. As Trooper Deleaver said: "We are not 'gung-ho' types, but if you have got a job to do then you do it the best you can."

Trooper Lilley

Trooper Deleaver

Pot to stay in Criminal Code: Lalonde

By Bryne Carruthers

OTTAWA — Many Canadians mistakenly believe planned legislation to lessen penalties for cannabis crimes by moving the drug from the Narcotic Control Act to the less stringent Food and Drugs Act represents a form of "decriminalization" of cannabis, according to Federal Health Minister Marc Lalonde.

Not so, he explained in a wide-ranging interview with **The Journal** on drug problems.

Even when cannabis is moved to the Food and Drugs Act, it will still have to be covered by the Criminal Code — that's where the federal government derives its powers in the drugs field.

Thus, in effect, as long as drugs such as cannabis are covered by federal laws (as opposed to just provincial laws), they will remain as "criminal offences."

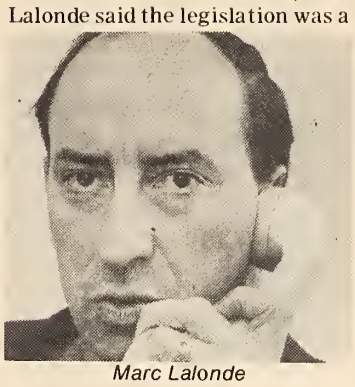
What the federal government hopes to do with the new legislation on cannabis is make penalties less punitive, Mr Lalonde explained.

The Health Minister, a lawyer, noted that if a Canadian resident fails to file an Income Tax return for 1976 until after the April 30 filing deadline, technically that person is open to criminal proceedings.

At the same time, Mr Lalonde admitted certain aspects associated with having cannabis covered by criminal proceedings — namely the existence of criminal records — are of concern to the government. And he confirmed earlier reports that the government hopes to be able to make some changes in this area when the new legislation is introduced in Parliament.

The Minister also admitted the proposed cannabis legislation has been "left around too long." But he tried to shift the blame to Opposition attempts generally to slow movement of legislation through the Commons.

Despite the fact a version of the cannabis bill passed by the Senate (after lengthy committee hearings) failed to get passed by the House, last session, Mr Lalonde said the legislation was a "high priority last session" and will be a high priority this session.



Marc Lalonde

But he said the new cannabis bill, to be based in part on the Senate version and to incorporate some additional modifications to be considered by cabinet early in the summer, won't be introduced again in Parliament until the government is sure it will pass. "I don't want to see it die on the Order Paper again."

This means it won't be introduced before the summer recess but more than likely will be introduced in the fall session.

Mr Lalonde admitted there is a danger the bill could get "lost in the shuffle" if a federal election is called later this year or early in 1978.

As an election gets closer, there will undoubtedly be political concerns that the cannabis changes are a "no win" situation, he suggested, despite the fact drugs don't generate the same sort of emotional reaction as an abortion debate, for example.

Mr Lalonde provided few insights into what additional changes he hopes to include in the new cannabis bill.

He said it would likely focus on cannabis possession penalties, and the "consequences arising out of possession penalties" — supposedly criminal records and parole provisions.

He also said he hopes to arrange better co-ordination of sentences for crimes other than possession (such as trafficking) with sentences for similar crimes involving other drugs.

In the case of trafficking, for example, the fact trafficking penalties for cannabis and heroin are the same means they are "too stiff" for cannabis and need to be changed.

On drugs generally, Mr Lalonde said his experts believe drug use in Canada has reached some kind of plateau.

Asked whether this just means younger people are switching to alcohol, Mr Lalonde commented that it is "probably easier to cope with a teenager getting a touch of booze than of heroin."

Treatment provisions are outmoded

(from page 1)

narcotic who had been previously convicted of either crime (on a separate occasion) would be automatically sentenced to "preventive detention in a penitentiary for an indeterminate period."

For a person on trial for possession, trafficking, or importation of narcotics (which still include cannabis, until the new law passes), the court, on application either by the Crown or by the persons charged (or his or her lawyer), has the option to commit the person for observation and examination for a period not exceeding seven days.

This would be done before the person is actually committed to trial or, if the trial is also committed, before a sentence is passed.

After such examination and observation, if the person is convicted and the court believes the convicted person is a drug addict (based in part on the evidence of at least one doctor), then the court "shall . . . sentence him to custody for treatment for an indeterminate period in lieu of any other sentence that might be imposed for the offence of which he was convicted."

People affected by this provision would have the option to appeal.

People sentenced to treatment would be confined in a penitentiary but could also be paroled. Those paroled who are also first offenders have, in effect, the mandatory treatment sentence lifted permanently after 10 years of parole and no further convictions.

The unproclaimed Part II also allows the federal government to provide penitentiary treatment for narcotic addicts who are convicted for other crimes, if provinces enact legislation allowing such an arrangement.

BC-federal government initiative

Heroin panel members are optimistic

(from page 1)

may get the drug free.

BC has been studying sterner options, such as the Japanese method of compulsory treatment of addicts, and the approach tried in some California communities of mass arrests of addicts.

Mr McClelland said he is happy about the federal-provincial initiative: "I think we convinced Ottawa that we're serious about going ahead with some program," and so Ottawa decided it should join in.

Members of the panel were optimistic they could accomplish their task in the short time available.

Bert Hoskin, head of the Alcohol and Drug Commission of BC, and Malcolm Matheson, of the Co-ordinated Law Enforcement Unit, said they were extremely pleased with the response of federal authorities, who agreed to set up the joint strategy committee within hours of a presentation by their organizations.

Besides Mr Hoskin and Mr Matheson the panel includes Supt. W. J. Neil of the RCMP criminal investigation branch, L. P. Landry, assistant deputy minister of Justice; Robin Bourne, assistant deputy minister to the solicitor general; and Ron Draper of the Non-Medical Use of Drugs Directorate.

Ron Basford

Panel members were reluctant to discuss what direction their deliberations might take.

Mr Hoskin and Mr Matheson, however, are considered heroin hard-liners. Both have in the past recommended some sort of compulsory treatment and "quarantining" for addicts.

Mr Basford said: ". . . our discussions now are centered around rehabilitation and getting the illicit drug sellers off the street."

Hepatitis research - two major difficulties past

(from page 1)

researchers have now expanded their study to more than 100 people and the same encouraging picture is emerging at the one-year follow-up point.

And phase one studies being conducted in the US, designed to show that the vaccine does not infect, are giving equally promising results.

"All the evidence to this point indicates it is safe from the point of view that it does not produce hepatitis."

Two major difficulties held up research until about five years ago.

First — there was no animal model. But by the early 1970s, it was possible to select primates who did not have protective antibodies to Type B hepatitis. These animals could now be selected and infected and show the same disease seen in man.

Second, the infective agent was isolated by Dr Baruch Blumberg who was rewarded with the Nobel Prize earlier this year for this work. Dr Krugman and his group found a way to inactivate the infecting inner part of the virus. It is the outer viral membrane which is used to immunize.

There is no shortage of raw material. Dr Krugman says there are carriers of hepatitis B who are apparently healthy despite the fact they have "billions and billions of these virus-like particles in every ml of blood. We have thousands of people in this country and elsewhere who have 10,000,000,000,000 particles per ml (10 to the 12th).

"So we don't need a cell culture. The human is cultivating it for us every day. All that was required was the technology to separate out the purified hepatitis B surface antigen from the infectious component."

But other studies have shown that by proper donor selection, it may be possible to get another gamma globulin against Type B which has antibody titres 50 to 1,000 times greater than in standard globulin. This too could be licensed "in the not-too-distant future," says Dr Krugman.

This new protective agent might be particularly useful to babies exposed to Type B infection. Studies have shown that an infected mother can pass on her hepatitis in more than 50% of cases to her child before or during birth.

Women who are carriers of Type B but who show no symptoms also can infect their children.

"So here we have a situation where the child is at risk and it is hoped these new gamma globulins will be helpful in prevention because some of these children do go on to develop chronic active hepatitis. There have also been cases where the children develop a fulminating type of disease. And yet others go on to a carrier state for long, long periods."

Hepatitis drug anti-cancer?

TORONTO — If the hepatitis vaccine fulfils its initial promise it could well be the first anti-cancer vaccine. There is a deep suspicion that chronic Type B hepatitis and carrier states may be precursors to liver cancer.

In countries with high carrier rates, the incidence of liver cancer is also high.

"So perhaps this Type B vaccine may be the first vaccine against cancer. For, if there is an association between a carrier state and cancer this could be immensely helpful in eradicating the first and thereby eliminating the second," says US researcher Saul Krugman.

There's a tranquillizer in the dregs

DALLAS — Wine residue acts as a minor tranquillizer and exerts a calming effect, according to a study by psychologists at Southern Methodist University.

They tested the activity and shock threshold of rats fed water, wine, and wine residue after removal of the alcohol and water content.

Water produced no effect.

But the wine residue alone increased shock thresholds and decreased activity levels to almost the same degree as the wine itself, reported Drs S. A. Golder, W. H. Tedford, Jr., W. E. Flynn, and E. R. Biehl.

"The effects appear to be those of a minor tranquillizer," they said in the *Journal of Studies on Alcohol.*

They estimated that a person drinking one-third of a litre of wine would get 18g of residue from dry wine and 55g from sweet wine.

If only 100 mg of the residue was psychoactive, this would be comparable in effect and dosage to minor tranquillizers such as meprobamate and chlorodiazepoxide.

Scotch hitting the rocks in the US of A

NEW YORK — Scotch whiskey sales, which grew spectacularly after World War II, reached a plateau about five years ago and now are heading downward.

Americans have been cutting down on their whisky consumption for a long time now, and the trend has been toward what the liquor industry call "white goods" — vodka, wine, rum, tequila.

But whisky distributors are battling back with some high powered artillery this year, says the liquor industry newsletter *Impact.*

Cutty Sark, the No. 2 selling scotch behind J&B Rare, will be backed by an advertising budget of $11 million this year, double what it spent last year.

The four top brands — J&B, Cutty Sark, Dewar's, and Johnny Walker — already control nearly half of the scotch market in the US.

Flexibility is manifest in USSR alcohol plans

Last year, in response to an invitation from officials of the Ministry of Health, Archer and Eva Tongue, director and assistant director respectively of the International Council of Alcohol and Addictions in Geneva, visited Moscow. In this article, Dr Eva Tongue describes the visit, during which they talked with officials concerned with problems of alcoholism and drug addiction and discussed questions of prevention, treatment, legislation, and research. Visits to a variety of institutions in and around Moscow were part of the program.

What does alcoholism mean in the Soviet Union?

Discussions soon made it clear that steadily increasing alcohol consumption has been a subject of long-standing concern in the Soviet Union, but it was only a few years ago that coherent legislative measures were instigated to deal with the problem. Although no detailed sociological or epidemiological studies seem to have been carried out, informed guesses by some officials can give a few ideas as to the major outlines of the problem. In the Soviet Union, alcoholism seems to be very largely a masculine problem; strong stigma still attaches to the female alcoholic. Women are rarely seen drunk, while excessive use of alcohol in men is all too noticeable, especially in the cities. According to the health authorities, treatment of women alcoholics is complicated by the fact that the alcoholism is often detected very late.

There are no differential data on drinking practices in the various parts of the Soviet Union, but informed observers consider that the Central Asian Republics — Uzbekhistan, Kazakhstan, etc. — would have rather fewer problems than most of the others.

Vodka — when, where, and how much?

The favourite alcoholic beverage in the Soviet Union remains vodka, sometimes by itself, sometimes drunk in combination with wine, beer, or champagne. A bottle of vodka costs from R 3.50 to R 4.00 which is the same as the price of 3 kg. sugar, 1.5 kg. beef, 1 kg. butter or two bottles of Russian white wine. On the other hand, a cup of tea costs 3 kopeks (100 kopeks = 1 ruble) and a cup of coffee 10 to 12 kopeks. Prices are set after consultations between the different ministries which might be concerned with alcoholic beverages.

Vodka is not hard to find: it is sold in most restaurants and food shops. In a restaurant, strictly speaking, a patron who is not eating should not be served with more than 1 dl. vodka. It is forbidden to serve minors under the age of 18 or to serve anyone visibly under the influence. Food shops keep very long hours; most are open from 7 in the morning until 10 or 11 at night, but alcohol is sold in a special department where sales are restricted to the hours between 11 in the morning and 7 in the evening; beer sales are exempt from these restrictions. On the other hand, spirits over 40% cannot be sold in shops on Sundays or holidays. No alcoholic beverages at all may be served in railway station buffets, in the canteens of working places or of the armed forces. The only exception to this rule is that wine is provided for sailors in tropical waters.

The alcohol blood level tolerance is 0.00 per ml. for drivers of anything mechanical, whether automobiles, tractors or engines, and for any kind of transportation workers in general. There is no exception to this rule and the consequences for breaking it are serious.

To be caught as a drunken driver is no joke in Moscow: the first time, the driver has his licence suspended for a year, the second time, for three years and should there be a third time, it will be taken away for him for life.

Basic Concept — Prevention and Treatment

One basic concept lies behind all preventive measures and treatment methods used in the Soviet Union: alcoholism is a disease, but the individual is responsible for the drinking excesses he committed before he became a compulsive drinker.

Since the comprehensive law dealing with alcohol and drug addiction questions was passed in 1972, there has been an increase in the division and decentralization of responsibilities for alcohol problems. The over-all coordinator body is the Subcommission on Alcoholism of the Ministry of Health of the Soviet Union, established in 1972 under the chairmanship of Vice-Minister D. Safonov.

According to the law, the Ministry of Health of each Republic is expected to set up alcoholism commissions in the Republics, as well as in the Autonomous Territories which enjoy considerable leeway in adapting policies to local conditions, and in districts and large cities. These commissions are regularly invited to report on their work to the central Subcommission which remains responsible for overall policy and whose membership is made up of representatives of the Ministries of Health and of the Interior, of the trade unions, and of experts in various disciplines as considered necessary. It meets at least eight times a year.

Prevention

All activity in the field of prevention is coordinated by the Central Institute of Health Education. Houses of Health are there to cooperate in carrying out the work on the local level in each Republic, in many cities, and districts. Tremendous effort is made to disseminate information, and every conceivable medium brought into play — newspaper and magazine articles, radio and television programs. lectures, films. Films are a particularly favored vehicle of information and have been produced in a multiplicity of forms tailored to a variety of specific audiences. All of this information is directed toward the healthy population, and not toward those who are already sick.

Detection

After information, the logical next step in a coherent alcohol program is an effort to detect alcohol problems early; this is effectively the case. In every large plant, factory, or administration there is a narcological post, mannered by a feldscher, a medical assistant, one of whose major responsibilities is to be on the lookout for alcohol problems.

Treatment

When a need for treatment becomes apparent, the patient is advised directly and may then seek treatment voluntarily, through the central narcological dispensary, a specialised unit of the psychiatric dispensary established in every city and district of the USSR. The narcological dispensary, the obligatory passage point for triage, decides where the alcoholic should be treated, in the alcoholism unit of a psychiatric hospital or in the narcological station set up near a plant. The narcological dispensary is also the hub of the aftercare system. It is there that the patient reports after institutional treatment. Aftercare is done either directly by the dispensary, or by referral to the narcological post in the patient's plant or to the policlinic with a narcological cabinet nearest his home. If any problems arise, the patient will be sent back to the dispensary. The follow-up procedure is usually extended over a period of at least three years after discharge from an institution.

Treatment in Psychiatric Hospitals

In the alcoholism units of psychiatric hospitals the minimum stay is 45 days, the maximum three months. Treatment methods vary widely, ranging from pharmacotherapy, including the use of apomorphine, antabuse, minor tranquillizers, and esperal implantation, to hypnosis. One of the most unusual is the administration of herbal teas. The physicians treating alcoholics introduce, at their discretion, any method they might find to be effective.

Once the first two week period of detoxification is over, patients treated in the psychiatric hospitals begin regular occupational therapy outside the hospital, but not necessarily in their own places of work. This occupational therapy is considered one of the important means of retaining contact with the ordinary world outside hospital. Family visits are encouraged, but during the whole hospital stay, patients are not allowed to receive any gift packaged in a bottle. The treatment is free, but the patient receives neither social security nor his salary during the period of his hospitalization. If, however, his alcoholism should lead to temporary or permanent disability, he will be pensioned as any other invalid worker.

. . . and in the Narcological Stations

The narcological stations, established in or near a number of large plants, are a particularly interesting innovation. Patients assigned to them continue their ordinary working routine during the day and receive treatment as in-patients in the evening. The minimum stay is two months and the maximum six. The value of this method comes from the fact that the patient remains in his usual environment and the moral and psychological support of his fellow-workers is considered part of the treatment. The workers are paid 60% of their salary during the treatment period. The other 40% covers the cost of their room and board at the narcological station. Medical expenses, doctors, nurses, and medication are all covered by the Ministry of Health.

Compulsory Treatment

Alcoholics who are recalcitrant in seeking treatment may be forced to it on the request of family, members of the trade union, or the comradely court of their work place. The validity of such a request must be ruled on by the district court on the basis of a hearing on the patient's status, showing that he presents a danger to himself and the society around him and that he is unwilling to seek treatment voluntarily. Once the court order — which is not a criminal record — is passed, the patient goes to one of the closed treatment institutions. Originally, the 1972 law stipulated that he stay there for a minimum of two years. Experience has shown that this time is often too long and the minimum time has been lowered to one year, and in some cases the chief physician of the institution has the discretional right to discharge a patient even earlier if he sees fit.

A patient discharged from compulsory treatment is required to remain in touch with the narcological dispensary for four to five years. It should be noted that "controlled drinking" is not accepted behavior for treated alcoholics in the Soviet Union.

The Criminal Alcoholic

Whenever a suspicion of alcoholism arises in the case of a person who has committed a crime, he cannot be tried until a forensic psychiatric evaluation has been made. Difficult cases from all over the Soviet Union are sent to the Srbski Institute in Moscow for observation. In general the observation time will not exceed one month; in the most difficult cases, there is the possibility of extending this to two months.

If a criminal is considered to be responsible for his act and is also recognised as an alcoholic, treatment will be provided in the prisons.

Sobering-up Stations

The sobering-up stations, to be found in Moscow as well as other large cities, are under the authority of the Ministry of the Interior and administered by the police. The clientele is divided into three categories: drunk and disorderly; helpless drunk; and those who commit anti-social acts. They come in after being picked up by special station wagons on a route drawn up by the police. Once a client is brought to the station, he is given a medical examination and, if there are no special indications, he will stay there as long as necessary to sober up, with three hours as a minimum stay. While the client is in bed he is under double observation with an attendant constantly at the door of each ward and a closed-circuit television receiver in the medical officer's room.

In Moscow, the cost of a sobering-up stay is 15 rubles; for those who have committed an anti-social act — smashed a window, insulted passers-by, etc. — there is an additional 10 rubles' fine. This money is deducted from the client's next paycheck, which means that his working place is informed immediately. The sobering-up station also tries to inform the family and, whenever possible, discharges the client to a family member. The station maintains contact with its ex-clients, their work places and their families; film and discussion sessions are held at intervals.

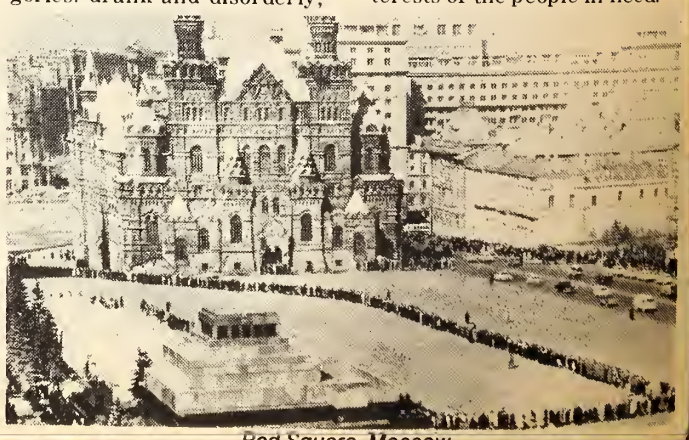
Research

Basic research into the biology of alcoholism is being carried out at a number of institutions in the Soviet Union. Among them is the Srbski Institute where the correlations between alcohol consumption and reaction time and alcohol consumption and sleep disturbances are under investigation. The alcoholism research department, set up only recently in the Pharmacological Institute of the Academy of Medicine, is now carrying out extensive animal studies.

All research is entirely financed by the government. Once a project is approved by the alcoholism subcommission of the Ministry of Health, the researcher is provided with all facilities to carry out his work. Social research into alcoholism problems is not being planned.

Summing Up

Whenever one considers the situation of alcohol, alcohol problems, and the treatment of alcoholics in the Soviet Union, it must be remembered that the whole structure only dates from 1972. The observer who visits the country is struck by the flexibility that is mainifest in dealing with the situation as it is clarified, as it evolves and develops. In the spirit of the 1972 law, it is clear that the intention exists to modify any of the links in the system, whenever and wherever it becomes apparent that such modifications would be beneficial in serving the best interests of the people in need.



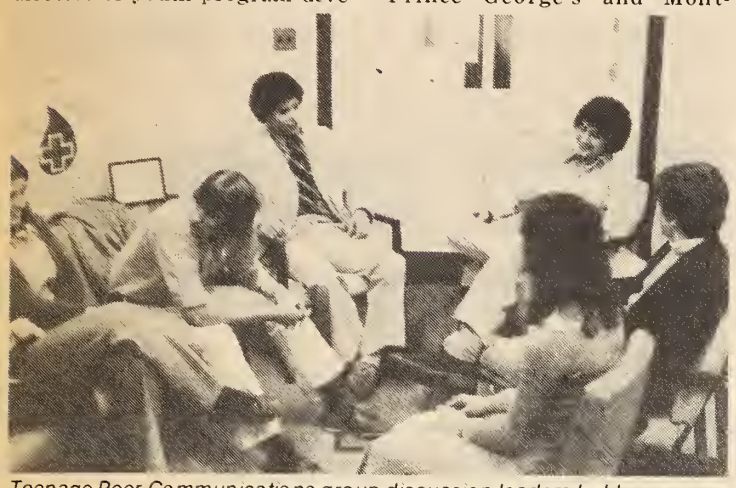
Red Square, Moscow

US Red Cross is moving into alcohol education

WASHINGTON — What began 16 months ago with an invitation to a conference is now leading to development of alcohol education programs that will probably be used here and abroad.

Already, Michael Lenaghan, director of youth program development for the American Red Cross, has been innundated unexpectedly with requests, even though pilot programs are not completed.

One is a peer group information program being tested in Prince George's and Montgomery counties adjacent to Washington, and the second, alcohol education modules being tried in Chicago and Wichita.



Teenage Peer Communications group discussion leaders hold a warm-up session on the use and abuse of alcohol at the Prince George's County, Maryland, chapter of the American Red Cross.

The National Institute on Alcohol Abuse and Alcoholism, which provides voluntary advice, happened to mention in December that the pilots were in existence.

Since then, provincial ministries of education in New Brunswick, Nova Scotia, Ontario, and Saskatchewan, ministries of education in Britain and Japan, and scores of Red Cross chapters in the US, have asked to be considered for possible testing and evaluation sites in the next stage.

(At present, the Canadian Red Cross has no plans for implementation of alcoholism education programs for youth, a spokesman told **The Journal.**)

But before the programs move ahead, checks and rechecks will be made to see they meet the absolute criteria of the Red Cross: accuracy and, above all else, neutrality, the key asset of the League of Red Cross Societies.

Mr Lenaghan points out that it takes four to six years for the Academy of Sciences to approve a new first aid textbook because "in regard to health and safety information, if the Red Cross says it, people believe it."

The same must be true with any information about alcohol. Every avenue is investigated.

Mr Lenaghan said: "We want to make sure we look honestly at everything because young people are certainly quick to catch on if you are trying to sell them something, as opposed to trying to help them work something out."

The process began last year when NIAAA invited the Red Cross to send delegates to a conference it held for a number of national organizations. Mr Lenaghan said that the Red Cross is established in 3,200 US communities but it was not sure what kind of contribution could be made in the alcohol field.

Although a number of organizations have some sort of program, after the conference "we saw a bit of a gap as regards to adolescents between 13 and 17 years old," he added.

However, Red Cross headquarters went through a lot of questioning as to whether it had any business at all in the alcohol education field. A prime mover was Laura Weil, a national volunteer consultant, who played devil's advocate and kept asking why not.

At about the same time, and quite independently, 27 Red Cross chapters, including Los Angeles and San Francisco, reported to Washington that they had studied their youth programs and found lack of alcohol information a major problem for teenagers in their communities.

Then the chapters in Prince George's and Montgomery counties passed a resolution that something should be done about the problem in their communities.

A decision was made to move, but the question arose of what kinds of programs to consider. "We felt the clinical approach was over our heads, and there were many and better resources in terms of specific problems than the Red Cross.

"But a transaction with a broad section of the youth population was fully within our capability," Mr Lenaghan said.

The result was the alcohol education module developed with help from NIAAA, and the peer communication model with help from Rod Moran, an adolescent psychologist, in nearby Virginia.

Later, both NIAAA and the industry Distilled Spirits Council told Mr Lenaghan while the pilot program approaches were good because they were neither pro nor con, "there is already a glut of stuff out there."

But, "the fact of the matter is, as we are now putting together something of a box score which is really the incidental survey that has happened since December, it demonstrates to us that there is a huge need.

"There may be good things out there, but a lot of people don't think they have got good things. They are saying, in effect, let us in on this because, frankly, we don't have the tools with which to work."

The Red Cross approach has two advantages. "We are not perceived as a competitor in special interest areas, and we are neutral. Our position is not one for or against alcohol.

"We never profess to be experts in a problem, but we do profess to attract the best volunteer professional advice, which would often cost the individual specialist agency more than they could afford."

The peer group program began with selection of 12 teenagers who were given 10 sessions of instruction and field experience.

These 12, working in pairs, now have six peer discussion groups going.

There is a sharp lookout for snags: "If you meet at a church, how creditable is that with some kids? Many said beware of meeting anywhere near a school."

While the parents of all 12 leaders attended a meeting, and demontrated the young people could communicate with their parents, "we are not sure the kids they are going to work with are going to enjoy that."

The six to eight sessions of the alcohol module programs are more straightforward and classroom orientated. Reactions have varied enormously in the two cities.

In inner-city Chicago, the gang-leader type of group showed "their street knowledge was much better than our module, but their scientific knowledge wasn't. When they saw what purpose we were trying to serve, they got a lot out of the sessions.

"In Wichita, which is more middle class, there is a 'dry state' mentality, and those with certain religious convictions raised some really good questions about the function of alcohol."

Michael Lenaghan

Health insurance for alcoholics?

CHICAGO — The Blue Cross Association in the United States has reached the half-way point in a study that could have widespread effects on the rehabilitation of alcoholics.

The project, which is funded by a $206,000 contract with the National Institute of Alcohol Abuse and Alcoholism, will determine the feasibility of private health insurance for alcoholism.

Treatment for the acute phase of alcoholism is now offered by more than 85% of Blue Cross plans.

Less than 10%, however, pay for the costlier and more prolonged phase of rehabilitation.

The goal of the study is to develop a comprehensive alcoholism treatment benefit package.

To this end, Blue Cross is examining the market potential of the plan, the rehabilitation services available, and the results and cost of treatment.

If found practical, economically feasible, and effective, Blue Cross will offer coverage to its clients throughout the US.

President of Blue Cross, Walter McNerney, says it is clearly in the interests of the alcoholic that prepayment mechanisms be used to remove the financial barrier between him and medical care.

Drivers should be taught how to drink, says AMA

CHICAGO — People need to be taught how to drink sensibly, says American Medical Association's safety education director Lee N. Hames, who urges that students be allowed to drink in driver education classes.

"It makes a lot of sense to me," he said in Chicago.

"The majority of these students are going to drink anyway, so why not under controlled conditions?"

"I'm not suggesting that we turn every school lunchroom into a cocktail bar," said Mr Hames, "but I don't think these kids realize what drinking does to their driving, and somehow the message has to be gotten across. Simply telling them not to drink when they drive hasn't worked."

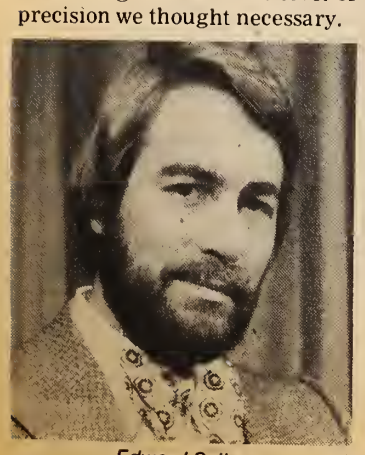
ARF enters a new wave of research

By John Shaughnessy

TORONTO — A clinical research facility, described by its director as "probably unique in the world", is now in operation at the Addiction Research Foundation of Ontario.

Edward Sellers, director of the Clinical Research Unit, told **The Journal** the facility allows experiments to be conducted with increased precision, it permits increased numbers of studies to be conducted, and its increased data handling capability furnishes the "reduced data more quickly so we can plan the next experiment."

In Dr Sellers' view, earlier biomedical studies at the foundation were hindered because the facilities didn't allow them to meet some of the long range research objectives. In particular, "it wasn't possible to quantitate drug effects to the level of precision we thought necessary.



Edward Sellers

"We wanted to develop something which would allow us to do the kinds of studies which we feel are the wave of the future in terms of clinical research. In effect, we wanted to optimize the conducting of human clinical investigation (in this field)."

The clinical research unit, with eight beds for biomedical investigation and four beds for behavioral studies, was developed to meet these goals.

Key to the unit is the noninvasive human responses measurement laboratory, run by Dr Dwayne Zilm. The laboratory consists of two rooms. One of these is the patient study room where various noninvasive measures can be taken, for example heart rate, galvanic skin conductance, tremor, pupil diameter, blood pressures, EMGs, and a variety of objective measures of drug effects.

The measures that are taken in the patient study room go by cable to an adjoining room with a one-way glass where all the heavy equipment for handling the signals and controlling the experiment is located.

Many of the advantages of the unit stem from a varian V76 mini-computer in the control room.

"The mini-computer allows us to handle data in a really unique way," said Dr Sellers. "It lets us take analogue signals, for instance an ECG, and we can convert it into a digitized mode which is easier to work with for statistical purposes. The computer can do that automatically. It will then store the data in the form we want, and it will transform it and print it out in the format we'd like to have."

The computer also permits multiple measures to be taken simultaneously. If blood pressure, heart rate, pupil diameter, tremor and galvanic skin response are measured at the same time, the computer will take the signals and separate them by a millesecond or two.

"For all intents and purposes that's at the same time," said Dr Sellers. "The computer takes the information and stores it, and we can have a printout at the end of the experiment of all the data we like. Furthermore, we can get measurements at desired intervals, for example a heart rate every five or 10 minutes."

The computer can also "interact" with the experimental situation. It can do this in a very rapid type of interchange where, for example, it's modifying the dose of a drug that's being given in response to a physiologic change in the patient, or it can interact much more infrequently.

An example of the latter situation would be a behavioral study where the investigators would want to control a dispenser of alcohol or drugs. The computer can be programmed to turn on the dispenser at regular time intervals or in response to specified actions by the patient. "It can obviously do more complex things than that," said Dr Sellers, "but the example illustrates one of its advantages. To have an observer sitting around and turning on the dispenser at the appropriate times is a very expensive proposition."

Another manpower saving option is that the computer can turn on a video camera that will automatically take pictures of a patient's behavior at random intervals over a given period of time, for example 24 hours.

"The noninvasive human responses measurement laboratory allows a precision and control of human experimentation which we believe is essential," said Dr Sellers. "We think this is the best way clinical research can be done in the area of alcohol and drug abuse."

But beyond the precision aspect, the unit allows greater use of the facilities. In the past, ARF investigators found it often took a full day to set up and conduct a single experiment. "With the new set up, we can change the things that are going to be measured in a matter of a few minutes," said Dr Sellers. "All we have to do is dial into a matrix switch what pieces of equipment we want to be hooked up, and then we're ready to go. The room is now converted for doing someone else's experiment."

Dr Sellers hopes that ultimately, besides providing high quality clinical investigations relating to alcohol and drug abuse, the unit can serve as a centre for education in this field.

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'Alvin, don't you ever have any suggestions for the garden?'

Comment

The drug junket name

By Michael Sack

IT HAS often been said that if one has the time and money (not to mention the inclination), one could be at a drug-abuse conference 365 days a year. Indeed, in the month of October, 1975, one could attend some 24 US national conferences, training sessions, etc, with at least 250 other drug-abuse gatherings going on in the various states during the same month. In Wisconsin alone, a busy attender could have worked nine separate workshops into a tight schedule.

The motivation to become an attender can come from as many directions as the imagination allows.

The prime one, of course, is the "need to learn more in your profession" (usually used on justification-for-attendance forms).

Others popular motivations are visiting old cronies (good for job-hunting), taking a vacation on the agency's nickel (self-explanatory), hunting for a new lover (national conferences are good for short term affairs, state conferences are better if your aim is for a 'meaningful relationship'), and on and on.

Fortunately, the events come in all sizes and shapes, and are conveniently located all over the map so that whatever your motivation, you can find a conference that fits your needs.

Whatever the reason, you can become a conference groupie. These are the people who show up at all the meetings, conferences, workshops, seminars, and what-have-you, no matter what the meeting is about, or where it takes place. These are the people who, after registration, scan the lists of participants for Long-Lost Friends. After recognizing some names, they will hunt the Long-Lost Friend up, and throw their arms around the unsuspecting victim with wild abandon. This establishes two things: a touchy-feely relationship (very important to the conference groupies); and a state of "in-

ness." (New participants, not ye initi
to the art of the groupie, can usual
observed watching this ritual from
sidelines, and muttering to themse
The mutter is usually to the effect tha
wish I was part of the in crowd.")

Following, then, are some helpful h
on how to become part of the in crow
short: How to Become a Confer
Groupie:

• Meeting other people is the most
portant ingredient in the making
groupie. (Remember a friend can
come long-lost until you know his
name). Therefore, always attend the
ting to know you exercises."

• Participate in the frantic shouti
names, the milling in circles and
passing of badges. Once things
quieted down (and you have memori
least two names and faces for l
reference and/or dropping), surve
group for the Most Interesting or
Looking Individual in the room. Fo
your way into his/her sub-group. (
The Most Interesting or Best-Lookin
dividual will usually have the larges
group).

• Wear your name tag proudly on th
day. On the second day, don't wear it
Be sure the name tag you wear is diff
from all the others. This will induce
illusion that you are staff, a speak
someone important. Need may be
mother of invention, but myth is
father of need. Once the myth is e
blished, all else follows.

• Maintain a list of people who are
portant in the field, and know
whence they come. Drop their na
frequently to new acquaintances (
you're from California! You must k
Dave Smith!). Dave Smith of course
be counted on not to expose you as
admitted to not knowing someone
years.

• Get a good feel of the other partic
attitudes toward the meeting. Are th

Inside Science

Task Force Report - 10 mo

By Norman Giesbrecht

SKID ROW inebriates continue to wander the streets, wait for liquor outlets to open, and get drunk in public — despite some noble efforts by researchers and practitioners.

Not so many years ago, the skid row inebriate in most Ontario centres was likely to have many of his drinking episodes interrupted by a policeman, be locked up, face a judge, and end up in jail. He'd begin to eat regularly, gain a few pounds, renew old acquaintances, and be off alcohol for from five to 30 days or even longer.

Everything seemed to be going well. Police and judges were busy and, because of the volume of business, managed to reduce the average length of court appearances to less than a minute. Jails were full and well-served by the men often considered less than useless when they were drunk on the streets.

Then, in the mid-1960s, some people began anew to question this approach — it was a great way to keep the streets clear and foster camaraderie among public inebriates, but it didn't seem to change the men's drinking habits or general lifestyles. The system was also discriminatory: an inebriate with neither money nor a home would receive an involuntary course in speedy justice while the man with resources would get a free ride home.

This led to the Task Force on Detoxication Planning whose report proposed a 125-bed detoxication centre in Toronto. The centre was to be linked to various longer term treatment programs such as self help houses. Comparable arrangements were proposed for other Ontario cities. The proposal was not, of course, accepted as it stood. An Inter-Departmental Committee on Chronic Drunkenness Offenders made some revisions. In particular, the multi-service centre where diagnoses and referral was to take place, a key component of the first proposal, was not incorporated in the revised model.

The first detox centre in the province opened in Toronto in June, 1968. By 1971, there were several in Toronto. That summer, the Liquor Control Act was amended (Bill 101) to allow police to take people to a detox centre in lieu of laying a charge of public intoxication, although the public drunkenness statute remained in effect and in use.

The Task Force and the Inter-Departmental Committee that had proposed the new approach, the legislative debates with regard to Bill 101, and ministerial submissions on the program, all clearly indicated the system was designed for the "care and rehabilitation of the chronic liquor offender" (Legislative Debates, July 6, 1971).

Furthermore, through a process of referral, the detox centres were to promote the integration of the chronic offender into the health care facilities, and the halfway houses were to achieve long-term rehabilitation objectives in the population referred to them.

By June 1976, there were 13 centres in 10 judicial districts, representing 265 beds. In Metropolitan Toronto, there were four centres by last summer with 78 beds (of the 125 beds proposed in 1969). Now, there are at least 22 provincial, long-term rehabilitation facilities, with about 320 beds.

While these facilities were being established, police and courts had already begun to be more lenient and more selective. And in most towns or cities with a detox centre, at least some people picked up for public drunkenness were diverted to centres instead of being charged. In Toronto, for example, there was a large increase in the proportion released after being charged (18% in 1961 and 85% in 1974), and an increase in suspended sentences (6% in 1961 and 73% of the sentences in 1971), which helped to account for a rather dramatic decline in the estimated man-days spent in the Don Jail for public intoxication convictions (121,000 in 1960-61 and 13,000 in 1971). Compared to the early 1960s, fewer individuals were arrested but those who were, were arrested more frequently. So the overall number of arrests did not decline substantially.

In short, except for the few who got special police attention because they were likely to come to personal harm or were obvious nuisances, skid row inebriates in Toronto, and likely in other cities of Ontario, were increasingly left to themselves.

How did the skid row inebriate respond to the revised situation of social control? Did the detox centres play a significant

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... Letters to the Editor ... Letters to the Editor

British group wants more FAS research

We found your report in **The Journal** (March) — UK women increase alcohol intake — interesting.

The studies David Ennals (Britain's health minister) refers to as indicating "connections between *heavy* drinking in pregnancy and malformation of a subsequent baby" are the collected abstracts and reprints of the literature on fetal alcohol syndrome which I brought to his attention prior to his address to the National Women's Organizations.

I had the collected abstracts and personal communications from Professor David W. Smith, University of Washington, Seattle, and Dr Frank Majewski, of Germany, compiled into a report by Dr John Wilson, consultant neurologist, Hospital for Sick Children, Great Ormond Street, London.

This report was eventually accepted by Mrs Renee Short, MP, chairman of the sub-committee in the House of Commons examining the problems of alcohol consumption in its interest in preventive medicine. The recommendations of Mrs Short's sub-committee were to be made known in April.

We do not know (at the time of writing) what is in Mrs Short's report but I shall be very surprised if the issue of the need to research fetal alcohol syndrome is mentioned.

In any case, we have our second All Faiths' World Alcohol Projects meeting on fetal alcohol syndrome in London on June 1st, 1977, when three of the world's most eminent men will deliver papers on this most important disease in terms of prevention. The papers and discussion will be recorded and published in the first issue of ALFAWAP Journal of the study of the effects of alcohol ($15 yearly subscription).

We have a strong following in the UK with well wishers in both the House of Lords and the House of Commons. We are bringing pressure on the Minister to order a study of the magnitude of fetal alcohol syndrome and to set up a Select Committee in the Commons to examine the field of alcoholism in total here in the UK.

A proliferation of professional and voluntary agencies with no inter-communication is the cause of much duplicated effort and sheer rubbish appearing in the lay press, on radio, and TV. Much of this "news" is the work of one and another of the countless bodies and organizations employing professional public relations people to get themselves editorial mention in any way at all.

The Rev Ronald Forbes
UK representative
All Faiths World Alcohol Projects
4 Woodchurch Road
London NW 6, England

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Agree with

them. Make sure you determine whether or not they were on the planning committee before you say, "Oh, yes, it's terribly disorganized! As a matter of fact I lost my schedule and haven't found my room yet". Or, "Yes, it's just great!! I had a really meaningful experience in the Mental Masturbation Exercise Workshop!"

- Page yourself at least six times a day, and when you hear the page, look pained and turn to the nearest individual with a sigh and say, "They never let you alone, do they?" and walk toward the house phone with an air of resignation.
- *Never* overdress. Blue jeans, work shirt, and briefcase are *de rigueur* for men. Puka-bead necklaces are out this year. For the women, peasant skirts, sandal wedgies, simple blouses, no bra, and lots of bangle bracelets are still in.
- Never let yourself be seen sitting alone in the lobby for too long. Look like you're going someplace. If necessary, go to your room and get your cigarettes, then return to your room for matches, etc, etc.
- Say "Hi! How are you?" to strangers. They will return the greeting before they realize they've never seen you before. By then, if your timing has been planned properly, you will have disappeared into an elevator. You will note, after trying this gambit a couple of times, that your victims on this ploy will invariably speak to you in the future. For one thing, they will recognize you. More importantly, they will not have been able to be sure that you were a total stranger the first time they saw you, and won't run the risk of offending you again.
- Always announce to some New-Found Friend (to become a Long-Lost Friend at the next meeting) that you must meditate before dinner. Then hide in your room and watch Gilligan's Island.
- Leave yourself a message on the message board. The second day, add the word "urgent" to the message. When someone eventually mentions it to you, say "It can wait!" and tear the message off the board at the next opportunity.
- Ask any two of the following questions at any presentation: Where did you get your statistics? Did you interface with the Criminal Justice System? or, Did you interface with the Health Delivery System? What about the Special Needs Population? How relevant is this to rural America? or, How relevant is this to urban America?
- Always sit on the outside of a tightly knit circle.
- Leave each session at least once to make your presence noticed.
- Never ask, "Who is that on the podium?"
- Walk in the bar and look for a non-existent person and leave.
- Walk in the bar, order a drink, and when someone talks to you, tell them you are waiting for someone. "I was supposed to meet Bob DuPont here. Well, he must have been detained".
- If the event is geared toward self-growth, memorize these phrases and use them frequently: I am really getting in touch with my feelings; Please don't crowd my space; I am centering myself and grounding myself; Meaningful relationship; Meaningful exchange; Meaningful moment; and Meaningful other.
- If the event is geared to the more bureaucratic, memorize these choice phrases: Interface with; Non-dysfunctional; Medical model; Single State Agency; state plan; and cost effective.
- Memorize the alphabet and use as many acronyms as possible.

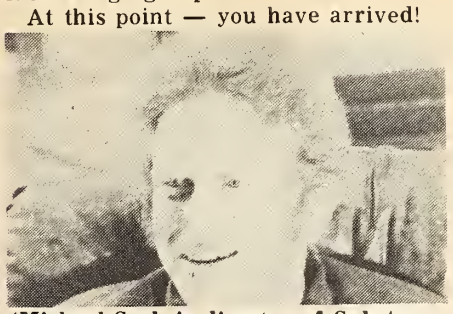
Now that you are becoming fairly successful at being a groupie on the drug-abuse junket, you find yourself wanting to attend more and more meetings. You may have the problem of getting off work to go to the events. Here are some helpful hints to get you out of work and to the meetings:

- Volunteer to be on a panel. (It's easier than writing a paper).
- Write a justification for the unique training you will be receiving.
- Join a professional organization or organize one.
- Start off by picking events in small, non-glorified places like Oshkosh, Wisconsin, Macomb, Illinois, etc, then progress to more popular places like New York City, Washington, DC, and eventually move on to San Francisco, Seattle, Honolulu, and Sweden. By then you will be on a planning committee yourself since you will volunteer continuously.

By now you are well into the Drug-Abuse Junket. You receive your copy of **The Journal** and know what is coming up next. You are on a number of planning committees. Your agency thinks you are terribly important. Your resume is three pages longer. You have been seen in at least one news conference and you can now greet people with a big "hello" and a hug. Your luggage is covered with tickets. You have a collection of more than 50 badges. You even know how to sneak into a convention without paying the registration fee.

You suddenly realize how bored you are and how much you miss just sitting at your desk, talking to a client, and facilitating a group.

At this point — you have arrived!



(Michael Sack is director of Substance Abuse Services, Winnebago Mental Health Institute, State of Wisconsin, Department of Health and Social Services.)

nths later the dust is still collecting

the rehabilitation of the chronic
nebriate? Was the detox-halfway
system operating as planned?
h studies conducted by staff of
aluation Studies and Social
Departments of the Addiction
ch Foundation addressed these
ns. The findings are summarized
Task Force II Report on the Oper-
nd Effectiveness of the Ontario
ation System.
ions of a sample of Toronto ine-
to more time outside jail was
Some claimed uninterrupted
onsumption was more than they
ke, and they consequently drank
day or had shorter sprees; others
t they spent most of their time
g. The majority claimed they and
kid row inebriates were in worse
now and that there had been an
e in muggings and beatings in
years. This observation was sup-
by a significant increase in the
nce of trauma in a comparison of
dical histories of 1961 and 1973
s. Most respondents appreciated
overy and caretaker services of
ox centres, but none saw them as a
rehabilitation.
e have had a mixed reaction:

early optimism gave way to disillusionment as experience showed the detox centres handle only a small proportion of those arrested and keep drunks out of circulation for a few days only. In Toronto, the total inebriates diverted to the detox centres recently ranged from 4% to 14% of those picked up for public drunkenness: the majority of those arrested are still being charged.

In 1973, an average of 62% of detox referrals across the province were from police. By 1975, the figure had dropped to 40%.

Many of those admitted to detox were not chronic public inebriates: in one study, up to 50% had never been arrested for public intoxication and many had stable accommodation and family ties. These and other indications suggest there was a gradual upgrading of the clientele, at least in some detox centres.

The referral rate to rehabilitation centres was low — about 10% of first admissions to detox centres. People admitted to post-detox facilities were not less likely to be readmitted to a detox centre or arrested for drunkenness than those not referred. There was little evidence detoxication contact had a positive effect on the clients' post-detox drinking behavior.

Possibly, expectations of managers and researchers were too optimistic, and the intractability of the skid row inebriate, underestimated. In any case, the Task Force II report concluded the present system left much to be desired and recommended several changes; that detox centres focus on the chronic public inebriate; that assessment and referral be emphasized; that longer stay be provided only for those seriously interested in referral; full decriminalization; and long term care for those not likely to benefit from rehabilitation.

Several recommendations were for trial projects and the most comprehensive proposal was for a gradual change — increase the number of police referrals to detox centres over a two year period.

The report was completed in June, 1976. In the past nine months, there has been no official public response.

* * *

Mr Giesbrecht is a scientist in the Social Studies Department of the Addiction Research Foundation of Ontario.

Skid row inebriates continue to drink in public despite noble efforts by researchers and practitioners.

Flexibility is AA byword

I read the article Many Alcoholics are Chronic Depressives First, by Manfred Jager, in **The Journal** (February 1).

It disturbs me, and many of my colleagues, to read prejudiced or at least ignorant statements about an organization that has pioneered and is still doing more for the recovery of alcoholics than any other combination of organizations and/or individuals.

If Dr Varsamis or Mr Jager or anyone would care to know what AA philosophy is all about, let them read the preamble of AA. In part it reads: *"AA does not wish to engage in any controversy, neither endorses or opposes any causes."*

Dr Varsamis, according to Mr Jager, said AA is incorrect in its uncompromising opposition to all drug therapy — lithium is a mineral and not a drug.

Dr Varsamis, Mr Jager, et al — AA is *not* opposed to anything!

Dr Nathan Brody of the Lakes Region Hospital in Laconis, NH has been using lithium, mega-vitamins, Antabuse, and other chemical agents in his treatment (Ortho-molecular Therapy) of alcoholics. Most of his alcoholic patients are referred to him by individual members of AA and they, the individuals, work closely with Dr Brody.

Hopefully, I contributed a little to your education — AA opposes nothing, individual members as individuals can oppose or endorse whatever they want; they as individuals do not and cannot represent AA — NO ONE INDIVIDUAL SPEAKS FOR AA.

Edward J. Stapanon, Sr.
Box 391
Londonderry, NH 03053

Anti-smoker campaigns fail to stop smokers smoking

By Thomas Land

GENEVA — The national anti-smoking campaigns around the world have made a huge impact on consumer demand and the tobacco trade but have failed to curb significantly the continuing increase of overall consumption, according to a specialist report submitted to an international conference here.

The study, offering a business-oriented assessment to organizations concerned with nicotine addiction and other forms of drug abuse, has been prepared by the secretariat of the United Nations Economic Commission for Europe. It provided the basis of a discussion at a recent meeting of the ECE Committee on Agricultural Problems in Geneva.

An important development of the past decade, probably a result of the anti-smoking campaigns, has been an increasing shift of demand towards mild tobaccos, low in tar and nicotine, and away from the dark produce.

World production of mild tobacco — flue-cured (Virginia) and Burley — has in fact been expanding during the past 15 years. But production of Oriental tobacco has now also recovered after a period of slump. The ECE economists forecast, in the long-term, a continuing 3% annual rise in the world consumption of mild cigarette tobacco — more rapidly in the poor countries than in the industrially developed world — and a gentle downward trend in the consumption of dark tobacco.

The study declares that "it is too early to judge the effectiveness of the anti-smoking campaigns but, if they are to influence firmly established habits, they will have to be planned as long-term undertakings".

Since the relationship between the use of tobacco and lung cancer was scientifically established in 1953, anti-smoking campaigns of many kinds have been set in motion by private organization as well as governments.

The study reviews a variety of additional moves implemented to make tobacco less harmful. Since 1972, laws have been passed in West Germany, Belgium, France, Greece, and Switzerland preventing or controlling the use of pesticides on tobacco crops and of additives applied during the manufacturing process. Attempts have also been made in West Germany and Switzerland to reduce nicotine and tar in manufactured tobacco, or to eliminate substances in cigarettes shown to be dangerous.

Filters have been improved and well over half the total number of cigarettes sold in 25 European countries now contain them. The use of filters has often involved a reduction in the average weight of tobacco per cigarette because the filter costs less than the tobacco it replaces. This, the economists observe, may have had some effect on the decline in demand in north-western Europe.

Synthetic products based on cellulose for blending with tobacco have been tried in West Germany and Switzerland, but they have not been well received by smokers. Several of the large chemical concerns have already abandoned work on synthetics; but research is continuing in the United States on the basis of cereals, and in Israel, using lettuce as a raw material.

The report concludes that "the combined effect of the anti-smoking campaigns and of related steps to make tobacco less harmful in north-western Europe has been to slow down the demand for the unmanufactured product.

"It is practically certain that synthetics will play an insignificant role and that natural leaf will be used almost exclusively in the future... The present shift in tastes towards mild, light, and less expensive cigarettes is affecting not so much the total volume of tobacco smoked as the relative importance of various types of tobacco and their sources of supply."

Stashed cash in cigarettes illegal in NZ

AUCKLAND — When one of New Zealand's cigarette manufacturers began randomly placing bank notes in cigarette packs as a marketing gimmick, it was not long before competing companies followed suit.

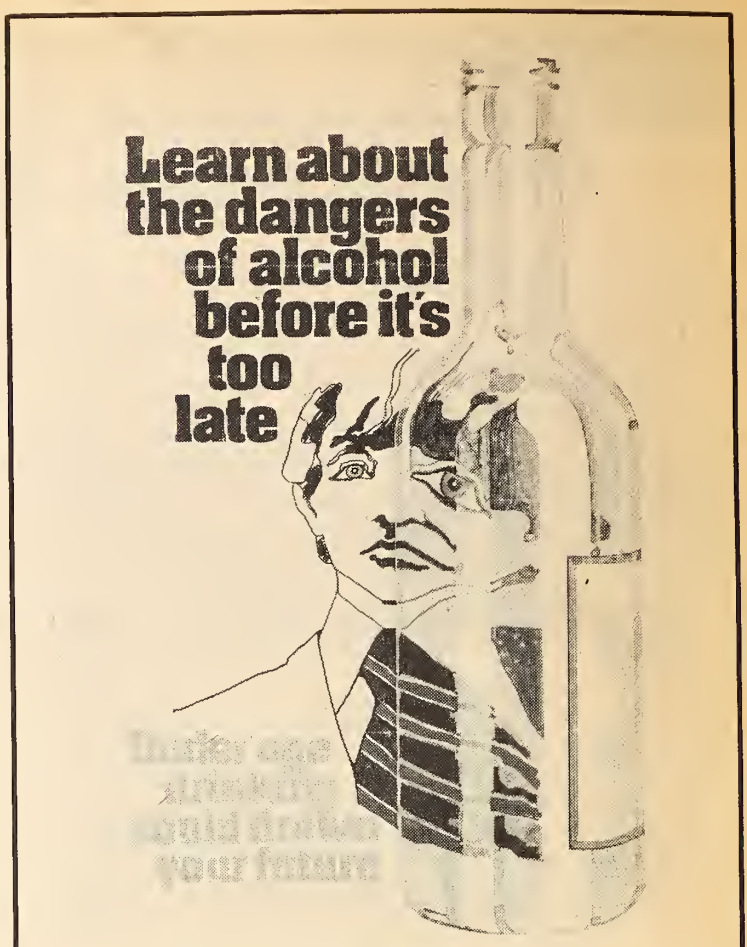
"You're in the money when you smoke Black and White," proclaimed the originator of the ploy, Philip Morris (NZ) Ltd, in an advertisement which major newspapers refused to run. Relying on world-of-mouth advertising, the firm continued dispensing $10,000 worth of one, two, five, and $10 notes. Its general manager said: "This is the most successful industry introduction in the last seven or eight years."

The St James Tobacco Company also had its advertisements rejected. Promoting the Albany brand, they featured the words "Albany Surprise" with a dollar sign replacing the "S" in "Surprise."

Confirmation of the newspapers' belief the give-aways were illegal, came when the Philip Morris company was convicted and fined $200 for a breach of the Gaming Act. The bank notes in the cigarette packets were prizes and not gifts, the magistrate ruled.

Following the decision, all manufacturers immediately stopped their give-away schemes. But the St James company revived its "Albany Surprise" advertisements, which the newspapers now accepted.

"Here is the philosophical poser," commented a financial paper, the *National Business Review*. "Now that money is no longer being inserted and the ads are free to run, the inference remains the same, even though the facts have changed. Is it, or isn't it, a case of misleading advertising?"



Warning to youth

This poster, produced by the Scottish Licensed Trade Association at an estimated cost of $2,000, is being distributed by the Scottish Health Education Unit, 21 Lansdowne Crescent, Edinburgh, Scotland.

Around the World

Smashing shebeens

Rioting black students in South Africa have ransacked shebeens (illegal drinking houses) and Government operated liquor stores, emptying drums and smashing bottles of alcohol in the streets. In October, the students gave shebeen owners an ultimatum to stop their illegal sales and destroy stocks. The students blamed drunkenness for the fact their earlier demonstrations against apartheid in education got out of hand.

Antipodean thirst

More than a million Australians spend over £22 a week on alcohol, the Victoria Federation on Alcoholism has reported. One in seven drinkers downs 22 glasses of beer a day, the foundation's report said.

AA model

The newest self-help group to model itself on the precepts of Alcoholics Anonymous is called Cui Bono — "for whose benefit is it?" Cui Bono is operated in London and is for men only — men convicted of indecent exposure and then referred by the courts to probations services.

Fully licensed

There were almost 100,000 special licences for drinking alcohol outside normal licensing hours granted in Scotland in 1975, according to figures issued by the Scottish Information Office. There were also 12,461 applications made for the sale of excisable liquor, of which 11,843 were granted.

Restrict drink ads

Dutch breweries have announced voluntary restrictions in their advertising campaigns following a warning from the Ministry of Health about rising alcohol consumption. The voluntary code of practice says that advertisements for low alcohol content drinks should not suggest they're safer than stronger products. Young people should not be encouraged to drink, and ads should not feature young drinkers or sports personalities.

Drink at work

Nine out of 10 problem drinkers interviewed in a Scottish survey admitted drinking before and during work, according to a report by the Tayside Health Education Department. Half the drinkers said they took a bottle to work occasionally, and one-eighth took a bottle to work every day.

Vintage cure-all

Wine can relieve a variety of ailments according to French doctor Emeric Maury in his book *Wine Is The Best Medicine*. The 73-year-old doctor claims that 70 afflictions ranging from gout to depression can be made better by one or two glasses of wine. People who are constipated should try two glasses of Anjou or Vouvray with each meal, while the best treatment for rheumatism requires four glasses of champagne. For a cold, flu, or sore throat, the doctor recommends three glasses of mulled Burgundy with cinnamon, sugar, and lemon peel.

Gamblers' fortunes

British punters spent £236 millions last year on the football pools, according to *Focus on Drink and Gambling 1976*, published by the Temperance Council of the Christian churches. Bingo fans spent £265 million trying to get a full house in 1975, and bets placed with bookmakers amounted to £2,026 million.

Beer ban

All advertising of beer is to be banned in Papua New Guinea. The decision, which followed strong pressure from churches and other groups, was announced by the Minister for Liquor Licensing, Pita Lus. Breweries were given one month to remove their advertising from theatres, newspapers, and outdoor signs.

Hungary's cigarette abuse worries officials

MUNICH — Cigarette consumption has nearly doubled during the past two decades in Hungary and according to official sources is beginning to have a serious detrimental effect on the nation's economy.

More than four million Hungarians — 40% of the country's total population, smoke regularly, according to *Magyar Tudomany*, the monthly of the Hungarian Academy of Sciences.

Total cigarette consumption has increased from 12.2 billion to 24 billion cigarettes annually since 1955 and according to the academy's report now averages 3,750 cigarettes per year for every Hungarian adult.

According to the publication, there has been "an alarming increase" in the nation's illness rate and in medical costs due to the "rise in tobacco consumption."

Hungary's 1974 national health bill was almost 5.2 billion forints ($251 million at the tourist exchange rate) and much of it was attributable to smoking. According to *Magyar Tudomany*, 20% of all time spent in hospitals can be traced to illnesses related to smoking, 15% to 20% of those Hungarians receiving sick benefits of one kind or another are suffering from tobacco induced ailments.

It is estimated 70,000 deaths yearly are premature and are caused by smoking.

An "anti-smoking society" was founded in Hungary two years ago and has been pushing for regulations and laws that would protect nonsmokers from smokers.

Highway safety should hinge on alcohol

WELLINGTON, NZ — There are no present indications that drugs other than alcohol merit traffic safety concern in New Zealand, the Summer School on Alcohol Studies was told here.

However, the potential involvement of illicit drugs should be studied, preferably by roadside survey using lip and finger swabs as well as blood/urine specimens, said Paul M. Hurst, of the Ministry of Transport.

He said the New Zealand Department of Scientific and Industrial Research has, since 1974, tested for Diazepam as well as alcohol in 850 cases of drivers killed or suspected of driving with excess alcohol (including hospital cases).

The presence of Diazepam, which accounts for 28% of all sedative drug sales in New Zealand, was identified in 19 cases (22%). Alcohol was also present in 16 of these, in 11 cases above the legal limit of 100mg/100 ml.

"Thus one can impute a causal role to Diazepam in only about 1% of the incidents giving rise to these tests," Dr Hurst said.

UK police smash underground drug markets

By Alan Massam

LONDON — British police, with the co-operation of American and European drug enforcement units, are claiming "success beyond our wildest hopes" in one of the biggest-ever raids on the illicit drugs market.

Code named Operation Julie it involved the mobilization of more than 800 police officers from 16 police divisions in England, Scotland, and Wales and the arrests of about 90 people alleged to be connected with the manufacture or marketing of LSD.

The drug ring is believed to have been involved in exporting large consignments of LSD to the United States as well as having a complex distribution network in Britain. Police estimated the racket was in the £100 million category.

Operation Julie had all the ingredients of a Hollywood film. The police, some of them armed, swooped on about a dozen suspected LSD "factories" some of them situated in remote Welsh cottages, just as dawn was breaking on March 26.

They smashed down doors with pickaxes and actually uncovered four "laboratories" where the drug could have been produced at a rate of 30,000 microdot tablets hourly. One LSD microdot tablet currently sells in the UK for about £1.

Later it was learned that US Narcotics Bureau had estimated the ring was exporting to the United States LSD worth hundreds of thousands of dollars monthly.

A senior British police officer said: "We have uncovered what might be described as an underground of drug supermarkets — the manufacturing centres, the wholesalers, and the retailers. It's fantastic."

Also raided was a lonely British-owned chateau in the Dordogne region of France, believed to have been used as a clearing house for drug manufacturing raw materials.

Operation Julie was led by Detective Superintendent Dennis Greenslade, deputy head of the South West Regional Crime Squad, who had been building up a dossier on illicit drug manufacture for more than five years.

Apparently, Greenslade's "troops" first realized they were on the track of a big LSD operation when they infiltrated a pop music festival held in 1975 and heard stories of the network of factories producing the drug.

Later the same year, an abandoned Land Rover was found in a remote lane in Wales with signs that it had been used as a mobile factory for making LSD. Also aboard was an ordinance survey map marked with a series of grid references. Subsequently police found these referred to pick up points where newly-manufactured LSD was dropped for collection by pushers.

SARDA tries acupuncture/naloxone

Hong Kong has new detox method

By Lachlan MacQuarrie

HONG KONG — A "promising" new method of drug detoxification which may be faster and less expensive than any method used here before, has been announced.

Brook Bernacchi, QC, chairman of the Society for the Aid and Rehabilitation of Drug Addicts (SARDA), the major voluntary drug treatment agency in Hong Kong, recently announced completion of an experimental project under the supervision of H. L. Wen.

Dr Wen, whose previous work in the use of acupuncture in the treatment of drug addiction has received worldwide attention, is chairman of SARDA's research sub-committee.

The new detoxification method combines acupuncture and electrical stimulation (AES), as used previously by Dr Wen, with the administration of naloxone (NARCAN).

The initial experimental project involved the successful detoxification of 36 male patients in the SARDA treatment program, who volunteered to receive the new treatment. They have since been transferred to the SARDA rehabilitation centre for follow-up and after care.

A documentary film demonstrating the new process of detoxification has been prepared by SARDA, and was shown recently to drug treatment and rehabilitation experts here. It has been demonstrated that while withdrawal on methadone alone takes an average of 14 days, and AES alone about eight days, the new method only takes three-and-a-half hours.

SARDA has announced plans for a further pilot project using this new technique which will serve as a follow-up study to the experimental work with the first 36 voluntary patients. If results are confirmed, it is hoped the faster and cheaper detoxification techniques could bring important benefits to drug rehabilitation agencies and their patients.

German kids still smoking

MUNICH — Although West German cigarette consumption has been decreasing during the past two years as a result of a concerted, government-sponsored anti-smoking drive, federal health officials feel their campaign has had little impact on the nation's youth.

The tobacco industry has issued preliminary figures that suggest a 5% to 6% decrease in cigarette buying during 1976 as compared to 1975. In 1975, there was a reported 31% decrease in per capita consumption as compared to 1974.

No smoking signs are now to be seen in an increasing number of public places, offices, transport agencies, and conventions, conferences, and congresses have begun adopting no smoking rules.

Dutch authorities launch major drug controls

By Jim Magee

AMSTERDAM — Under heavy pressure from neighboring countries, and by France in particular, to tighten up drug controls, the Dutch authorities have responded with a far-reaching program that offers lessons worthy of international study.

In marketing parlance, Holland is a "natural" for drug traffickers. It has several big ports, sits at the mouth of the Rhine, Western Europe's main waterway, has a busy international airport and frontiers with Germany, Denmark, and the Benelux grouping (Belgium, Luxembourg).

"Not only are we at the centre of a European transit structure, but we also have a tightly-knit Chinese community, organized into powerful secret societies that have links to Asia", comments Dutch Health Ministry official Cornelius Van Gruting.

Now that the French connection via Marseilles has been virtually severed, drug traffickers, and particularly heroin smugglers, have transferred their activities to the Netherlands.

One of the first steps taken against the growing activities of drug operators is tough new legislation, enacted at the end of 1976, which imposes severe penalties. Target of the new laws is the international dealer in what the Dutch call "drugs carrying unacceptable risks," meaning heroin in particular. He faces up to 12 years in jail and a fine of $100,000. The penalty for possession with intent to distribute (ie at national level) has been raised to a maximum of eight years in jail and a fine of $40,000.

A separate sanction has been introduced for possession for personal use — up to one year's imprisonment or a fine of $200. The aim of this clause is to enable the authorities to compel heroin addicts to undergo hospital treatment, if they will not go voluntarily.

In the view of the Dutch, cannabis use is not a social danger, but since the Netherlands is a party to the Single Convention, sanctions against the drug have to be maintained.

It is interesting to see how they have dealt with the problem. Once again, the main target is the dealer. Dutch police say the bulk of the international cannabis traffic, and especially traffic in THC, is in the hands of local criminals. The penalty for international trafficking in cannabis is maintained at four years in jail, but for local dealing it is reduced from four to two years.

How do you distinguish between a trafficker and a user? "We have a rule of thumb," comments Van Gruting. "If someone is found with 30 grams or more, he is considered a dealer. If he has less than that amount, he is considered a user only".

In the latter case, a separate sanction has been introduced for simple possession of cannabis for personal consumption. The penalty is a maximum fine of $200 or one month's detention.

To back up the legislation, key city police forces have been expanded, and a special national drug squad has been formed which works both with local officers and also links with international action against drug trafficking via Interpol.

One of the first moves was a series of swoops by police cars and tracker dogs in the China-towns of Dutch cities. Helping the raids was a Chinese-speaking policeman recruited with the help of Interpol from Hong Kong. That led to a considerable increase in business for travel agents, because more than 200 Chinese have been deported since December.

The crackdown, which hit the whole Dutch underworld, led to a sharp rise in heroin seizures, up from some 60 kg in 1975 to nearly triple that amount in 1976. At the same time, street prices shot up from about $20 a bag to $120, a development which the Dutch police interpret as a sign that supplies are getting scarce.

There is more to all this than heroin, however. On one hand, the new legislation is much wider than before, and applies controls not only to substances covered by the Single Convention, but also to substances in Schedules I and II of the 1971 Convention. The net has also been spread to bring in a number of psychotropics with CNS-stimulant effects which are not under international control.

The sting is that the legislation can be extended to still more substances, and the evidence suggests that controls are coming up for alcohol and tobacco, on the ground that they represent a serious danger to public health.

In the meantime, Dutch officials indicate their position on cannabis is identical to that expressed by the United States National Committee on Marijuana and Drug Abuse. They believe the Single Convention should be amended so each nation is free to determine for itself the extent to which cannabis and traditional cannabis products may be allowed for personal use, provided stringent efforts continue to prevent distribution and to prohibit export and production of drugs for illegal use in other countries.

There are eight patterns in world drug abuse: UN

GENEVA — There are eight main trends and patterns of drug abuse around the world, according to a report prepared by the United Nations Division of Narcotic Drugs.

The information in the report was drawn from annual reports of governments, and statements made by each country's representatives at the meeting of the Commission on Narcotic Drugs in 1976.

The eight main patterns, summarized in the report are:

- **an upward trend in heroin addiction;**
- **an overall widespread abuse of cannabis;**
- **an increase in cocaine abuse mainly in the Americas and Europe;**
- **an increasing abuse of psychotropic substances, mostly sedative hypnotics and amphetamines;**
- **abuse of methaqualone, amphetamines, and hallucinogens predominantly by young people;**
- **multiple drug abuse emerging as the most common pattern of drug taking;**
- **use of traditional drugs — opium, cannabis and coca leaf — persisting in a number of countries;**
- **in countries where opium is traditionally consumed by middle-aged and older people, the situation is becoming complicated by the rapidly increasing abuse of heroin among young people in urban areas.**

The report says most countries of the world are now confronted with serious problems of addictions to opiates.

"The increasing abuse of heroin by young people (smoking and injection) in urban areas is the pattern which causes great concern, particularly in the Americas, Asia and the Far East, Europe, and the Near and Middle East. This also applies to abuse of morphine though to a much less extent.

"Abuse of other opiates, mainly synthetic narcotics (methadone, pethidine) is spreading in most regions of the world."

Cannabis, it says, is the most widely abused drug in all regions. While its abuse has spread in recent years among young people in urban areas, its traditional consumption is persistent and prevalent in many countries among different age groups in both rural and urban areas. It is the drug most commonly taken in combination with alcohol or other drugs.

The large number of people chewing coca leaves "constitutes considerable socio-economic and public health problems for some Andean countries of South America.

"The increasing abuse of cocaine which has recently developed particularly in the Americas and Europe, is also an important characteristic of drug abuse. Cocaine is abused to a very small extent in certain countries of other regions.

The tendency to abuse psychotropic substances continues to increase in all regions. Abuse of barbiturate type drugs — methaqualone, tranquillizers — shows an upwards trend in most countries. Methaqualone is taken predominantly by young people while barbiturate abuse is more commonly encountered in middle-aged people.

Increased abuse of amphetamine type drugs among young people is also a current pattern in all regions, the report says.

"An increasing tendency to use combinations of drugs is one of the major characteristics of the present drug abuse patterns in all regions. Although drugs are used in all kinds of combinations, cannabis, alcohol, and barbiturate type drugs are those most commonly involved," it says.

More evidence on birth defects theory

By Thomas Hill

GAINESVILLE, Fla — A woman who drinks alcohol chronically during pregnancy stands a 50% chance of having a child with some degree of mental retardation, according to Jaime Frias, director of the University of Florida's March of Dimes Birth Defects Center here.

There's also a 30% chance the youngster will have "additional multiple physical malformations," adds the University of Florida geneticist.

During the past two years the university's Birth Defects Center has seen four children with defects fitting the description of what is called the "fetal alcohol-syndrome." They ranged in age from three to six years and showed evidence of growth deficiencies, subtle eye malformations, and mild to moderate mental retardation.

"All four of these children needed to attend special education classes because of their retardation," says Dr Frias. All of them remained short of stature, he adds, and were unable to catch up on growth as do most other children whose birth weight is below normal. They were born to chronic alcoholic mothers who felt they had to continue drinking in order to function, even during pregnancy.

Dr Frias is a participant in a nationwide, federally funded study of children with patterns of multiple malformations. In some of his work in connection with this study, he has found the fetal alcohol syndrome ranks second only to rubella as an environmental producer of birth defects. This finding is based on a review of more than 50,000 pregnancies and followup studies of children through their seventh year of age.

The idea that alcoholic women might give birth to feeble minded children isn't new. Eighteenth century physicians used to worry about this possibility but it wasn't taken seriously by most people because there was no proof and they tended to think it was based on Victorian attitudes rather than scientific fact.

But evidence has been building up slowly. Today, Dr Frias points out, more than 200 published case histories give clear documentation of the fetal alcohol syndrome.

Among the defects that have been associated with this syndrome are: abnormalities in development of the eyes (including crossed eyes and small eye openings); microcephaly (unusually small head); cleft palate; abnormalities in structure of the ears; some forms of congenital heart disease; small upper jaws; and various joint problems.

Dr Kenneth Jones and Dr David W. Smith, pediatric researchers at University of Washington School of Medicine, in Seattle, reported in 1973 on eight youngsters with a pattern of serious birth defects, who were all children of chronic alcoholic mothers. They now have collected 41 cases, all displaying the typical pattern of growth deficiencies and varying degrees of mental retardation.

Dr Frias and his co-workers at the University of Florida Birth Defects Center are now taking a close look at the alcohol-induced malformations. One aspect of the syndrome that has investigators worried is that it appears from studies in pregnant animals that alcohol readily crosses the placenta and remains in the fetus for long periods of time in high concentrations.

No one knows very much yet concerning such questions as (a) the level of alcohol consumption required to cause defects, (b) the stage of pregnancy during which the fetus is most likely to be affected; and (c) the exact property in alcohol that causes the malformations.

The question has been raised whether the fetal alcohol syndrome might be caused, not by the alcohol itself, but by the malnourishment that is often secondary to alcoholism. "Present evidence doesn't favor this hypothesis," says Dr Frias. "The causative agent appears to be within the alcohol itself."

A woman who drinks alcohol chronically during pregnancy stands a 50% greater chance of having a child with some degree of mental retardation, according to one researcher.

1971 findings contradicted

Pot/cerebral atrophy studies

CHICAGO — Extensive marijuana smoking over a number of years does not lead to cerebral atrophy, according to evidence from two new studies.

The results contradict findings in a 1971 study that both neurological symptoms and intellectual impairment occur among heavy cannabis smokers.

In one of the new studies conducted by a Harvard Medical School team headed by Dr John Kuenhnie, 19 men were supplied with marijuana of uniform strength and allowed to smoke at will during a 21-day inpatient study.

The men were first kept off drugs for five days then given a series of psychiatric, medical, and neurological tests. For the following three weeks they smoked marijuana freely.

The heaviest smoker smoked 163 marijuana cigarettes containing one gram of cannabis each, while the lightest smoker had only 51 cigarettes. The average for the group was 111 or five a day.

On tomographic x-ray scanning, none of the men showed any evidence of central nervous system damage.

In the other study, conducted by a team from the University of Kansas Medical School and Washington University Medical School in St Louis, marijuana smokers and controls were examined for brain damage by computerized transaxial tomography.

The subjects were 12 men from a group of heavy drug users who were compared with 34 controls who had never used drugs.

The drug users had been heavy smokers of marijuana for at least five years prior to the study and smoked an average of nine marijuana cigarettes a day.

The results in both groups were within the normal limits for both subjects and controls.

"The only prudent conclusion drawn by the midwestern group, which was headed by Dr Ben Ko of Washington University, was that "young men with extensive exposure to cannabis over a number of years do not necessarily show evidence of cerebral atrophy."

The Harvard group said marijuana smoking may produce changes in brain function that cannot be detected by tomographic scanning.

Both research teams said their findings do not necessarily invalidate those of the group in 1971 headed by Dr A. M. Campbell.

The Campbell study used pneumoencephalography to examine for brain damage.

For the zero, to two-year-old group

Children's use of medication declines in US

By Thomas Hill

MIAMI BEACH — Do North Americans over-drug their young children?

Updating some earlier studies of the subject, two investigators at the University of Rochester have uncovered some moderately encouraging data.

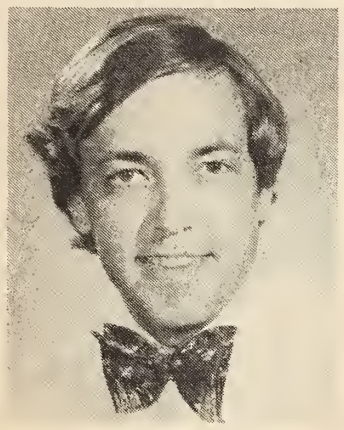
Andrew A. Sorenson, associate professor of preventive medicine and community health, and Klaus J. Roghmann, associate professor of sociology and pediatrics, found a general decline between 1971 and 1975 in the proportion of children from 0 to two years of age using certain categories of medication.

Dr Sorensen told the 104th annual meeting of the American Public Health Association here that interviews with parents had produced figures showing declines for the 0 to two age group in the use of pain relievers, cold and cough medicines, medications for skin conditions (except for an increase in girls), all medications for acute conditions, chronic care medications (except for boys), and vitamins and tonics.

In most categories, girls in this age group received medication more frequently than boys. Dr Sorensen pointed out this is in line with sexual differences in the drug usage of adults, several studies having noted women use proportionately more drugs than men.

For children in the three to five year age group the pattern in 1975 was "strikingly different" from that seen in 1971. In the earlier study, girls this age were more likely to receive most categories of medicines than boys — generally parallelling the situation for the younger children.

But in 1975, the girls in the three to five year age group received fewer medications than boys in every category except medications for skin conditions.



Andrew Sorenson

The Rochester investigators identified a number of factors that seemed to influence the amount of medication that parents give their young children. These included:

- When the mothers had chronic childhood illness, the children were more likely to be given acute and chronic care medications, vitamins, and tonics than were children whose mothers did not have chronic childhood illness.
- The higher the socioeconomic area in which children live, the greater their use of medications.
- Drug or medication usage was not strictly a function of income.
- Children in families covered by private insurers (in 1971) or Medicaid (in 1975) were likely to receive fewer acute care medicines, vitamins, and tonics than their counterparts in families without such coverage.
- Children in families who had two or more physicians used more drugs than children of families with one physician, or none, or who had a regular place such as a health maintenance organization (HMO) that provided their health care.
- Mothers with the lowest and highest amounts of formal education reported giving less chronic care medicine to their children than did mothers with medium education.
- Black mothers gave fewer drugs than white mothers.
- Catholic mothers were less likely to give the three main categories of drugs to their children in 1971 than Protestant mothers, but were more likely in 1975.
- The higher the status of the father's occupation, the greater the likelihood that the children would be given vitamins and tonics.

Dr Sorensen and Dr Roghmann noted many factors contributing to the use of over-the-counter and prescription drugs by pre-school children remain to be studied. They intend to do studies designed to explore the impact of such factors as parental drug use, sibling drug use, and TV advertising.

Dr Sorensen has been doing some pilot studies concerning the influence of drug advertising on drug usage by young children. "Although it's too early to report on these studies," he said, "I strongly suspect that the behavior of children is profoundly influenced by the millions of dollars spent annually in efforts to increase their use of over-the-counter drugs."

He noted most studies have focused on adolescence as the starting point of drug use. But much more emphasis should be placed on "the littlest children," he contended.

Cannabis is his 'cocktail'

TOPEKA, Kansas — A Kansas legislator who admits to smoking marijuana was recently questioned under oath about where he gets his supply.

State Representative Michael Glover, a 29-year-old law school student, was quizzed by local prosecutors after a federal judge ordered him to submit to the inquiry.

Authorities refused to discuss details of the questioning.

Mr Glover, co-sponsor of a bill that would reduce penalties for marijuana possession in Kansas, was quoted in a newspaper as saying he had used marijuana for several years and considers it his "cocktail."

Top twenty drug problem areas named by INCB

(from page 16)

seizures of this substance, particularly in North America and Western Europe. World seizures figures were approximately one and a half tons in 1974 and almost two and a half tons in 1975. The question arises whether illicit world demand for this substance is not in fact much greater than has been previously thought. In these circumstances, the board naturally appeals to governments to exercise even greater vigilance because, sooner or later, this latent abuse may assume epidemic proportions and would then be difficult to eradicate.

Africa

Most African countries have so far been fortunate in that they have not experienced any serious problem of opiate traffic or abuse. Almost all governments of these countries have, however, reported abuse of cannabis and more recently, psychotropic substances, particularly amphetamines, have appeared on the illicit market in increasing quantities. In the absence of effective controls, the problem of diversion of psychotropic substances to the illicit market, could rapidly become more serious in African countries.

The board considers that African countries, which have not yet adopted legislation relating to the import, distribution, and use of psychotropic substances, should do so quickly, in line with the provisions of the 1971 convention. Since the convention does not provide for a system of estimates for medical needs, it is essential that African governments, like those of other countries in the world, should themselves make a systematic estimate of their needs for psychotropic substances and limit the importation of those substances to amounts.

Pot threatens road safety

WASHINGTON — The greatest danger marijuana poses today to American society is to road safety.

Robert DuPont, director of the National Institute on Drug Abuse, in the sixth annual report on Marijuana and Health, says the real concern about marijuana use is not possible biological damage but "its potential effect on automobile accidents in this country.

"As marijuana becomes more acceptable to society, more users are likely to drive cars while under its influecne."

He cites a recent study in Boston of 300 drivers who were involved in fatal accidents: 36% had been using alcohol and 16% marijuana.

Dr DuPont said the situation — it is estimated there are now 15 million marijuana smokers in America — "makes more urgent the need to develop a simple way to detect marijuana in the body."

The report discounts the majority of studies which claim to show that marijuana causes abnormal chromosome breakage, brain damage, and adverse hormone and immunological response levels.

However, it notes the intoxicating effect of the drug results in loss of psychomotor response. There is also a danger of lung impairment after heavy and sustained use.

The report adds that marijuana is part of the cultural mainstream of American life and can be classed with the other popular recreational drugs — alcohol, tobacco, and caffeine.

New Books

by RON HALL

Alcoholism Problems In Women and Children

. . . edited by Milton Greenblatt and Marc A. Schuckit

In the first part of this book, the contributors address alcohol problems in women, and while each stresses more careful research is necessary, research evidence is presented. In one chapter, the investigators found the course of alcoholism in women and men is quite similar. One difference, however, is the high rate of depressive disease in women alcoholics. Another contributor reports that sex-role conflict, though not the only reason, is a contributing factor in alcoholism among women. Other chapters review the literature on the influence of the spouse and mother on the alcoholic picture, the biological perspective, alcohol problems in women homosexuals, and treatment. In dealing with alcohol problems in children, the chapters in the second part of the book cover the changing drinking patterns, parental influences, alcoholism in adoptees raised apart from their biological alcoholic parents, and maternal alcoholism and the outcome of pregnancy.

(Green and Stratton, Incorporated, 111 5th Ave, New York, NY, 10003. 1976 297p. $19.50.

Therapeutic Communities for the Management of Addictions

. . . by Gail Frankel, Robert C. Brook, and Paul C. Whitehead

This critically annotated bibliography of the English language literature provides the full citation and accompanying annotation for some 305 items found in scientific and professional journals as well as books, brochures, and pamphlets. Annotations tend to be critical in that "highlights" and "low lights" are mentioned in order to reduce the number of dead-ends that one will have to pursue in attempting to answer a particular question. The work is indexed using 230 key word indicators which include the names and locations of specific programs.

(Addiction Research Foundation of Ontario, 33 Russell St, Toronto, Ont. M5S 2S1. 1976. 222p. $7.

The Drinking Driver

. . . by Barent F. Landstreet

Enforcement, judicial, rehabilitation and treatment, and public information and education countermeasures which were developed for dealing with some 14,000 apprehended drinking drivers are described in this book. Each program is explained and methods for implementation, including types of local resources and training of personnel, are outlined. Chapters cover the drinking driver on the highway, the consequences of alcohol use and abuse, apprehending the drinking driver, classifying and rehabilitating the DWI offender, DWI and the public, and program planning, organization, and management.

(Charles C. Thomas, Publisher, 301-327 East Lawrence Ave, Springfield, Illinois. 1977 126p. $10.75.)

A Primer on Chemical Dependency

. . . by Joseph Westermeyer

Subtitled A Clinical Guide to Alcohol and Drug Problems, this book is primarily intended for the medical or surgical practitioner, although it should be of use to other workers in the health care field. Topics covered include models for chemical dependency, predisposing factors, the dependency syndrome, medical epidemiology, clinical diagnosis, treatment modalities, public health planning, and the physician and chemical dependency. The author indicates this text is meant for the busy practitioner with limited knowledge or experience in the field, and he provides suggestions as to how to use the book.

(Williams and Wilkins Company, Burns and MacEachern Limited, 62 Railside Rd, Suite 3, Don Mills, Ontario, M3A 1A6. 1976. 245p. $13.25.)

Interactions of Abuse

. . . edited by Elliot S. Vesoll and Monique C. Braude

This volume contains the proceedings of the first Conference on Interactions of Drugs of Abuse, March 9-11, 1976.Complexities of the neuronal, extraneuronal and genetic factors of drug interactions are analyzed, behavioral aspects are explained, and clinical effects are examined. Twelve of the 38 papers presented deal with molecular, cellular, and clinical aspects of drug interactions, while the remaining papers cover topics concerned with interactions involving drugs of abuse, including marijuana, narcotics and narcotic antagonists, depressants, stimulants, hallucinogens, and others.

(Annals of the New York Academy of Sciences, volume 281. New York Academy of Sciences, 2 East 63rd St, New York, NY, 10021. 1976. 500p $42.

Other Books

The Rendezvous: A Case Study of An After-Hours Club — Roebuck, Julian B., and Frese, Wolfgang. The Free Press, New York, 1976. Overview, literature review, theoretical orientation, methodology, patron types, employee types. Bibliography, index. 278p. $10.95.

Theories of Social Work With Groups — Roberts, Robert W., and Northen, Helen (eds). Columbia University Press, New York, 1976. Index. 401p.

A Complete Guide to Therapy: From Psychoanalysis to Behavior Modification — Kovel, Joel. Pantheon Books, New York, 1976. Neurosis and therapy, varieties of therapeutic experience. Glossary, index. 284p.

Focus of Control: Current Trends in Theory and Research — Lefcourt, Herbert M. Lawrence Erlbaum Associates, Hillsdale, 1976. The concept, control as an enduring attitude, social learning theory, resistance to influence, cognitive activity, assessment, Appendexes, references, indexes. 211p. $13.95.

Special Issue on Drug Abuse — Urban and Social Change Review, 9(2):1-40, 1976. Narcotics policy, British treatment clinic, women and drugs, addiction concepts. $2.50.

Effects Of Labeling the "Drug-Abuser": An Inquiry — Williams, Jay R. National Institute on Drug Abuse, Rockville, 1976. Research Monograph No 6. Labeling process, crime, apprehension, self-concept, laws. Bibliography. 39p.

Cannabinoid Assays in Humans — Willette, Robert E. (ed). National Institute on Drug Abuse, Rockville, 1976. Research Monograph No. 7. 119p.

Implementation of Power Motivation Training As A Rehabilitative Countermeasure for DWIs — Boyatzis, Richard E. McBer and Company, Boston, 1976. Training, politics of innovation. 111p. $5.50.

Identification of Countermeasures For The Youth Crash Problem Related to Alcohol — Preusser, David F., Oates, John F., Jr, and Orban, Marlene S. Dunlap and Associates, Inc, Darien, 1975. Literature, review, survey of young drivers, countermeasures. References, appendexes. 224p. $8.

Annual Report and Account 1975-1976 — Institute for the Study of Drug Dependence, London, 1976. 24p.

The Vermont State Plan for Drug Abuse Prevention And Treatment: Fiscal Year 1977 — Agency of Human Services. Alcohol and Drug Abuse Division, Montpelier, 1976. 198p.

A Never-Ending Relay Race — Law Reform Commission of Canada, Ottawa, 1976. Fifth annual report for the period June 1, 1975 to May 31, 1976. 31p.

Alcoholism Treatment Programs Directory 1976 — Information Planning Associates, Rockville, 1976. "A comprehensive listing of all alcoholism treatment programs operating in the United States of America and its territories". 476p. $10.95.

Information Sources in Criminal Justice — Newton, Anne, Peel, Kathleen Yaskiw, and Doleschal, Eugene. National Council on Crime and Delinquency Hackensack, 1976. "An annotated guide to directories."

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell St. Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

INPUT 77: 2nd National Conference on Occupational Alcoholism and Drug Abuse — May 1-4, 1977, Ottawa, Ontario. Information: Phyllis Buirds, Humber College, Conferences and Seminars, Centre for Continuous Learning, PO Box 1900, Rexdale, Ont. M9W 5L7.

American Psychiatric Association Annual Meeting — May 1-5, 1977, Toronto, Ontario. Information: Robert Robinson, director, Division of Public Affairs, APA, 1700 18th St NW, Washington, DC, 20009.

Solvents, Adhesives and Aerosols — May 11, 1977, Toronto, Ontario. Information: M. Miller, Industry Branch, Ministry of Industry and Tourism, 900 Bay St, Queen's Park, Toronto, Ont, M7A 2E2.

The Chemically Dependent Woman: Recognition, Referral, Rehabilitation — June 4, 1977, Toronto, Ontario. Information: Heather Rowe, The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 32I.

Annual Meeting of the Canadian Tuberculosis and Respiratory Disease Association, Canadian Thoracic Society — June 13-15, 1977, Moncton, New Brunswick. Information: Canadian Tuberculosis and Respiratory Disease Association, 345 O'Connor St., Ottawa, Ontario, K2P 1V9.

Canadian Guidance and Counselling Association 1977 National Conference — June 14-18, 1977, Montreal, Quebec. Information: The Secretariate, Congress National SCOC 1977, 1895, Avenue de La Salle, Montreal, PQ, H1V 2K4.

The Canadian Medical Association and Quebec Division Annual Meeting — June 19-24, 1977, Quebec City, PQ.

2nd National Symposium on Driver Education — June 23-25, 1977, Toronto, Ontario. Information: Canada Safety Council, Traffic Section, 1765 St Laurent Blvd., Ottawa, Ont, K1G 3V4.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference — FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

Institute on Addiction Studies — August 14-19, 1977, McMaster University, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Dr, Suite 603, Don Mills, Ont. M3C 1Yb.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference Headquarters, c/o The Portage Institute, 3418 Drummond St, Montreal, PQ.

1977 World Congress on Mental Health — Aug 21-26, 1977, Vancouver, British Columbia. Information: Secretariat, World Federation for Mental Health, 2255 Wesbrook Mall, University of British Columbia, Vancouver, BC, V6T 1W5.

21st Annual Meeting of the American Association of Automotive Medicine — Sept 14-17, 1977, Vancouver, British Columbia. Information: Traffic Injury Research Foundation of Canada, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

20th Annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

United States

National Council on Alcoholism — American Medical Society on Alcoholism 8th Annual Medical-Scientific Meeting — May 2-4, 1977, San Diego, California. Information: Frank A. Seixas, National Council on Alcoholism, 733 3rd Ave, New York, NY, 10017.

Industrial Training Seminar on Effective Methods for Helping the Alcohol and Drug Dependent Employee — May 4, 1977, Lionville, Pennsylvania. Information: Bob Forman, Malvern Institute, PO Box 297, Malvern, PA, 19355.

National Drug Abuse Conference-1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, Cal, 94117.

Conference of the Commonwealth Prevention Alliance — May 25-27, 1977, Tamiment, Pennsylvania. Information: Phyllis Hirschfield, COMHAR, 107 East Lehigh Ave, Philadelphia, PA.

Alcoholism: The Dynamics of Intervention and Recovery — June 1-2, 1977, Louisville, Kentucky. Information: Joe Trabue, department of HPER, University of Louisville, Louisville, KY, 40208.

American Medical Association Annual Meeting — June 18-23, 1977, San Francisco, California. Information: James H. Sammons, 535 North Dearborn St, Chicago, Illinois, 60610.

1977 New England School of Alcohol Studies — June 19-24, 1977. Colby College, Mainc. Information: Jan Swift Durand, coordinator, PO Box 11009, Newington, CT, 06111.

6th Ohio Drug Studies Institute — June 21-24, 1977, Westerville, Ohio. Information: Jim Shulman, Ohio Bureau of Drug Abuse, State Office Tower, 30 East Broad St, Room 1352 A, Columbus, Ohio, 43215.

35th Annual Session of the Summer School of Alcohol Studies — June 26-July 15, 1977. Information: Rutgers University, New Brunswick, New Jersey. 08903.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Centre, McLean Hospital, 115 Mill St, Belmont, Mass, 02178.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking" — July 27-29, 1977, Seattle, Washington. Information. Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, LSeattle, Wash, 98195.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977, Honolulu, Hawaii. Information: Rosa Torres, Congress coordinator, 6th World Congress of Psychiatry, 1700 18th St NW, Washington, DC, 20009.

1st International Symposium on Marijuana — Sept 10-12, 1977. Baltimore, Maryland. Information: Research and Treatment Foundation Inc, 222 East Redwood St, Baltimore, MD, 21202.

Alcohol and Drug Problems Association of North America Annual Meeting — Sept 25-29, 1977, Detroit, Michigan. Information: ADPA, 1101 15th St NW, Suite 204, Washington, DC, 20005.

National Alcohol and Drug Treatment Outcome Evaluation Conference — Sept 26-27, 1977, Nashville, Tennessee. Information: Linda C. Sobell, director, Alcohol Programs, Dede Wallace Center, PO Box 40487, Nashville Tenn, 37204.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism Oct 26-30, 1977, New York City, Information: ALMACA, 11800 Sunrise Valley Dr, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, AZ, 85010.

(Section on conferences abroad will be resumed next month).

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The rich and poor share drug-related problems

INCB singles out the worst in the world

By Anne MacLennan

GENEVA — The United Nations has 144 member countries and territories; between 15 and 20 of them share the dubious distinction of having the most serious drug-related problems in the world.

The problems may relate to massive drug abuse, to uncontrolled or illicit production of raw materials used in the manufacture of drugs, or to illicit traffic in drugs. And the list of the worst 20 includes the rich and the poor, the big and the small.

They have been singled out for special mention by the International Narcotics Control Board in its annual report to the United Nations Commission of Narcotic Drugs.

Following are the countries and territories and some of what the INCB has to say about them:

Near and Middle East

Afghanistan: As in most countries where opium and cannabis are produced illicitly, it is very difficult to assess, even approximately, the total illicit production of these substances in Afghanistan. The government believes, and the board is of the same opinion, that only by taking general measures of a social and economic character would it be possible permanently to reduce the illicit production of opium. This would require considerable international financial assistance.

Iran: Opium addiction is very widespread in Iran and heroin addiction is also prevalent. The number of registered opium addicts is gradually increasing and amounted to approximately 177,000 in 1975. According to the government, this figure is far from reflecting the real number of opium users. All opium produced licitly is intended for consumption by registered opium addicts. In April 1976, the government launched a new and vigorous policy. Licit distribution of opium will be supervised more closely and centres issuing authorizations for purchase of licit opium will be reduced. The government hopes that within 10 years, use of opium and the need for regular opium production will have ended.

Pakistan: The main problems of narcotic drugs control here are connected with illicit production of opium and cannabis; traffic in these substances; and non-medical use of opium, principally in urban areas. Measures to prevent diversions of licitly produced opium to the illicit market are not yet satisfactory. Morphine licitly imported into Pakistan has been found in international illicit channels. The government plans to register opium addicts to determine the extent of the problem. Pakistan's Narcotics Control Board has also taken steps and is considering others which should improve the situation. This is difficult and drug control authorities may need further support.

Turkey: The Turkish government has introduced measures to prevent opium production on its territory and is continuing to strengthen them. The board's information is that prohibition of opium production is strictly respected and no government has reported seizures of opium of Turkish origin in the illicit traffic.

East and South East Asia

Burma: Drug addiction is widespread in both urban and rural areas. Illicit and uncontrolled production of opium, mainly from the Shan State, continues at a very high level and the situation remains one of great concern. The government has further intensified measures against traffickers and has pursued eradication of illicit cultivation.

The Lao People's Democratic Republic: Nomadic or semi-nomadic hill tribes have cultivated the poppy on patches of burnt land for generations. The opium thus produced illicitly is mainly consumed locally by members of the tribes. In February, 1975, the government concluded an agreement with the United Nations and a UN/Lao Program for Drug Abuse Control was drawn up. An office has been opened at Vientiane which provide *inter alia* a permanent liaison between Lao authorities and UN bodies.

Thailand: The main narcotic control problems here remain illicit poppy cultivation by hill tribes in the north; steadily increasing drug addiction, principally in urban centres (authorities estimate the number of addicts to be between 300,000 and 500,000 including approximately 50,000 heroin addicts); transit through Thai territory of opium and opiates from abroad and intended for illicit traffic in both the region itself and in Western Europe; clandestine manufacture of heroin; and use of Bangkok by traffickers as a transit point.

It is not easy to control very long frontiers over which opium and opiates enter Thailand from abroad. This is why, although development of regional and inter-regional cooperation in search of solutions to problems which arise "downstream" of Thailand is welcomed, it is nevertheless certain that cooperation with neighboring countries which are at the source of its problems "upstream", is also essential.

Malaysia: Drug abuse has increased rapidly in Malaysia in the past five years. Although opium had been used for some time, it was previously smoked by only a very small number of people, mostly elderly. Recently, the nature and extent of drug abuse have changed greatly. It must now be regarded as a much graver danger, both nationally and internationally.

Since 1971, increasing numbers of young people in Malaysia have been affected by misuse of cannabis, morphine, heroin, and psychotropic substances. Malaysia is also a transit country for heroin from South-east Asia to Western Europe.

Recent legislation provides for severe penalties; enforcement agencies in countries concerned have instituted close collaboration; and centres for treatment, detoxification, and rehabilitation have been established. Despite these developments, dangers of a rapid increase in drug abuse cannot be overemphasized and unless rigorous measures are applied, Malaysia may soon be faced with a long term problem which would seriously threaten it from both the humanitarian and material points of view.

Territory of Hong Kong: There are very many addicts in Hong Kong. Twelve new evening detoxification centres have been opened; more than 1,500 addicts have been registered; and methadone is administered under medical supervision. Social rehabilitation is emphasized but difficult in this densely populated area. Enforcement services have made a substantial impact recently but the vast network of air and maritime services linking the territory to the rest of the world, adds to the difficulty of controlling illicit traffic.

Nepal: Nepal has to cope with three major drug problems — uncontrolled production of cannabis, which reportedly grows wild, chiefly in the western part; growth of drug abuse among young Nepalese; and inadequate control over licit movement of drugs.

Nepal is not yet a party to any international treaty on narcotics. The board regularly requests Nepal for information on licit movement of drugs but replies are sporadic. The solution, as in many other countries, is to be found basically in the social and economic development of a part of the country. As elsewhere, the financial resources that have to be devoted to this developmental effort are well beyond the government's capacity and multilateral and bilateral assistance will have to be sought. This also presupposes the government will agree to give increased priority to drug abuse control and take energetic measures against traffickers.

Eastern Europe

Drug addition is relatively minor in Eastern European countries, and apparently limited to the chronically ill and, in isolated instances, to members of the medical profession. The size of transit traffic and vigilance exercised by authorities, is reflected in the number of seizures made regularly.

Western Europe

Expansion in illicit traffic and drug abuse in several countries is a cause for great concern. Traffic in cannabis is still very considerable and that in cocaine continues to rise. It seems psychotropic substance abuse is expanding, particularly in multiple combination.

The most important trend, and one causing the most concern, is the continually increasing appearance of heroin on the illicit market and its eventual effect on illicit demand. Seizures, which doubled in volume in 1975 as compared to 1974, rose again considerably in 1976. Most of the heroin comes from Burma and Thailand and much is routed through the Malaysian peninsula. This drug is apparently destined, in the first place, for the Netherlands, where Amsterdam is still the main distribution centre in Western Europe, and appears to be transiting mainly through France and the Federal Republic of Germany but also through other European countries. Certain indicators point to a very serious increase in misuse of heroin in the Federal Republic of Germany and, apparently, to a less degree but still significantly, other countries including Belgium, France, Italy, the Netherlands, Sweden, and Switzerland.

Netherlands: Considering the gravity of the situation, the government of the Netherlands has taken steps against illicit traffic. In 1976, a National Drug Unit was formed in the Ministry of Justice, particularly to coordinate information on heroin traffic. Under new legislation, penalties for people using drugs will be reduced while those relating to traffic, particularly in drugs involving "unacceptable risks" (opiates, amphetamines) will be more severe.

North America

Mexico: Illicit consumption of heroin is still relatively limited and confined to towns along the Mexico-United States border. However, there's been a rise in the extent of demand and heroin addicts may now number in the hundreds. Authorities are concerned with cocaine traffic across the country from South America to the US. Abuse of cannabis is comparatively widespread among urban youths. Authorities are also concerned with widespread solvent sniffing, particularly among young people.

Illicit cultivation of the opium poppy and of cannabis occurs over a vast area. The development is relatively recent in Mexico where it seems organized crime syndicates have deliberately encouraged farmers to undertake this illegal activity. The governments of Mexico and the US have recognized the need to cooperate.

United States of America: Heroin availability on the illicit market increased last year. Cannabis abuse still takes place and abuse of cocaine continues to increase. Certain psychotropic substances have given rise to a problem of abuse, often in multiple combination, and are the subject of substantial traffic. In 1976, law enforcement activities intensified and prevention and treatment measures increased.

South America

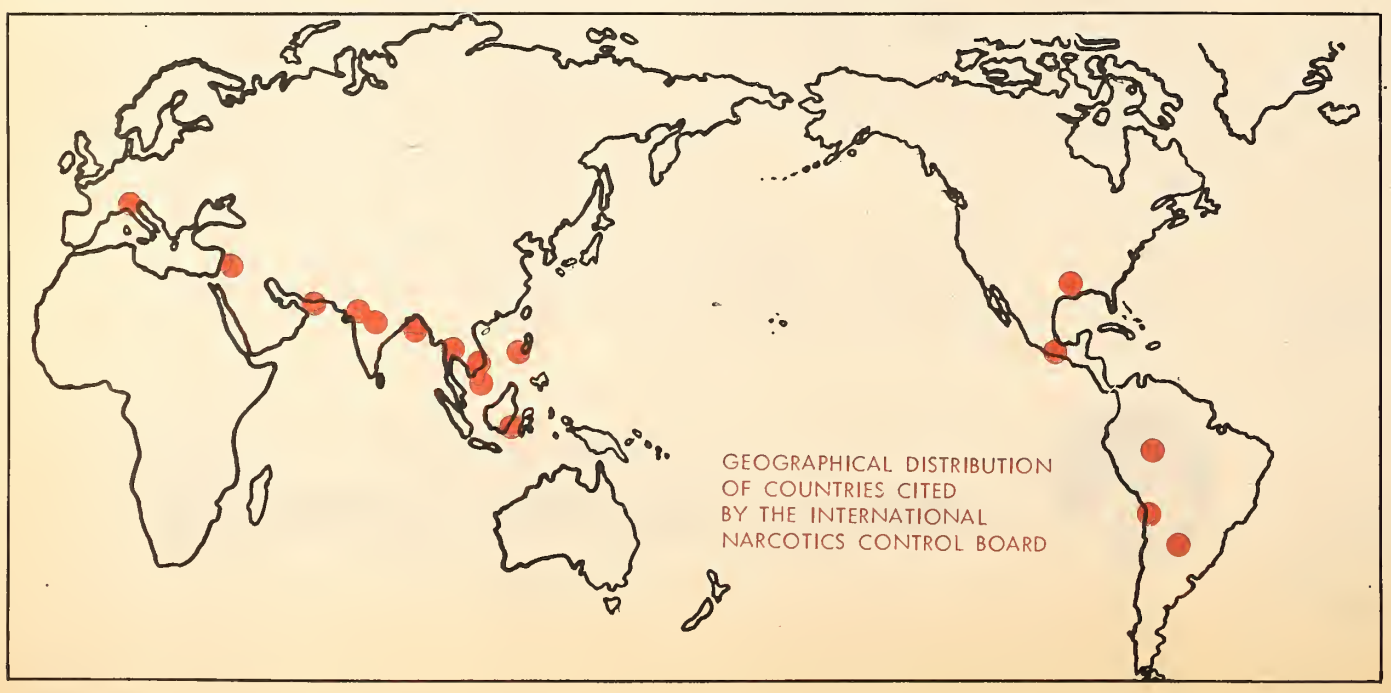
Despite increased cooperation among many countries and increased enforcement activity by some, there has been no apparent decrease in the volume of cocaine and cannabis of South American origin available in the international illicit market. Most countries of this region are affected by drug abuse and trafficking.

Colombia: It's an important transit country for drugs smuggled from South to North America. Smuggled into Colombia from neighboring countires, coca paste is converted into cocaine hydrochloride. Authorities discovered and closed 12 laboratories for cocaine manufacture in 1975.

Bolivia and Peru: Coca leaf production probably remains the most difficult drug control problem in South America. The chewing of coca leaf, mainly in Bolivia and Peru, but also in Argentina, Brazil, Colombia, Ecuador, and Venezuela, accounts for a substantial proportion of the material produced. But it appears that an equally large if not larger proportion is destined for the illicit manufacture of cocaine. Peruvian authorities estimate the amount of cocaine manufactured in this way might be of the order of 20 tons. It may be assumed a similar amount is available from Bolivia.

There has been a steady increase in

(See — Top — page 13)



The Journal

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US changes focus to a global view

By Anne MacLennan

SAN FRANCISCO — The United States in the next four years will be moving to a global rather than national concern with the narcotics problem.

This was one message brought to the meeting here of the National Drug Abuse Conference by Peter Bourne, the man President Jimmy Carter has named head of the new US Office of Drug Abuse Policy.

Dr Bourne, one of the key figures in the Carter campaign for president, told the meeting the US "cannot any longer work towards getting other countries to help us with our problem in the trafficking area if we are going to ignore their serious addiction predicaments.

"We ultimately do not want America to try to deal in isolation but to try to get other countries to take on a shrewd responsibility in dealing with narcotics as a global problem."

He suggested this was one area in which "you will see some broad policy changes during the next few years."

His office also plans to implement a narcotic policy that will be geared to establishing priorities in the drug field.

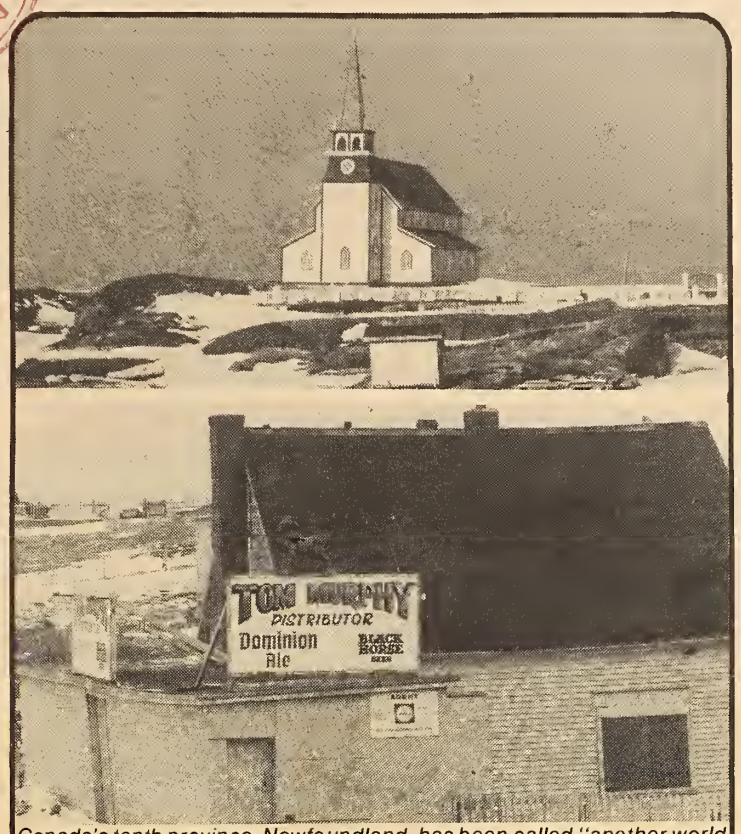
"We will look first to the clearly determined health and social hazards that various drugs provide to society. These priorities will be according to what the real risk is to American people."

He also hopes to establish a policy that takes into account what is "realistically accomplishable and what is not."

He referred to President Carter's longstanding "personal commitment to reducing the toll of drug abuse".

"As president, he has reinforced his concern by establishing the Office of Drug Abuse Policy to coordinate all the

(See — Prevention — page 7)



Canada's tenth province, Newfoundland, has been called "another world next door," and more lately, an "Atlantic orphan." In isolated outports, churches (Pound Cove, above), and liquor outlets (Bell Island, below), are the prime centres of social activity. While alcoholism rises alarmingly, treatment and prevention of alcohol and other drug abuse remains a low priority for the government because money is scarce and times are hard all around. See The Back Page.

American cultivation of scarlet unlikely

SAN FRANCISCO — The United States will probably not permit commercial cultivation of the scarlet poppy (*Papaver bracteatum*) although a final decision has not yet been made, according to Peter Bourne.

Dr Bourne is head of the newly formed US Office of Drug Abuse Policy and President Carter's chief adviser on drug affairs.

"We will probably continue to allow experimental, technical development studies so we have that alternative in reserve as a source for medicinal needs in the future should this be required.

"But, we don't see any great merit in allowing domestic commercial cultivation of that kind of poppy at the present time," he said.

Papaver bracteatum is a source of thebaine which, in turn, may be converted to codeine. The US move to cultivate it commercially, prompted largely by US pharmaceutical companies and professional medical associations, has drawn criticism from around the world. (**The Journal**, Jan, April).

International opinion suggests the delicate balance now existing between supply and demand for licit opiates could be seriously disturbed by production of this poppy in the US. Most codeine is now processed from *Papaver somniferum*, the opium poppy, growing of which is strictly controlled.

One problem, however, is that *Papaver bracteatum* is grown more economically than *Papaver somniferum*.

"We would be very happy, I think, in the world in general, if there was a gradual move towards the cultivation of *Papaver bracteatum* and the elimination of *Papaver somniferum*, in particular in India and Turkey where the poppy is grown for medicinal purposes.

"Our real concern about growing it in this country, is that we feel it will be misinterpreted by other countries that we're asking to control cultivation. And we don't want to create problems with the Turks or the Indians by domestic cultivation."

However, he said, Turkey will probably soon move to cultivation of scarlet poppy because

(See — Future — page 7)

NIAAA plans national prevention program

By Anne MacLennan

SAN DIEGO — The National Institute on Alcohol Abuse and Alcoholism is developing a statement of policy, issues, and strategies for a US national program to prevent problems related to alcohol use.

"We expect that new social experiments in prevention will be initiated in the next fiscal year," Ernest P. Noble, NIAAA director, told the annual meeting here of the National Council on Alcoholism.

"This program will encourage public acceptance and personal participation throughout our population," Dr Noble said.

He said there is "scant evidence" any malady can be controlled by merely identifying and treating it as it develops in the individual.

"I am thoroughly convinced that prevention is the only way to diminish the epidemic proportions of alcohol problems that are rampant in this country today.

"Therefore, we at the NIAAA, while not subordinating any of our other thrusts — as a matter of fact we are expanding and improving our efforts in research with the States, and in the quality of service to special populations — are giving new emphasis to prevention.

"We must prevent the financial, social, and health disasters that inevitably occur when alcohol is used in a way that violates human dignity, the dignity of the individual, and the dignity that should be inherent in our relationship with others."

He said NIAAA prevention action is being directed at four problem areas. "We are concentrating on dealing with the problems of alcohol use as they affect the family, high risk groups, casualties, and demeanor — which means drunken behavior.

"We are not limiting our spectrum merely to what can be called problem drinking, we are studying the causes and what might prevent inappropriate drinking."

While the individual was the primary focus in the past, "now we are going to examine the agent as well and strategies that pertain to the alcohol use environment.

"We must recognize we are working to change social mores regarding this use of alcohol."

As control policies and price can affect consumption of alcohol and many of its consequences, he said, a "formidable list" must be considered of such policies that relate to drinking behavior and its more unfortunate consequences.

He said NIAAA, as a federal agency, wants to provide leadership in initiating programs responsible to current attitudes and lifestyles among varied groups in the total population.

It wants to bring about the acceptance of public and personal participation improving the quality of life for citizens.

"We recognize that differing attitudes about alcohol and its use are complex and ambivalent. We are still subject to the emotions generated during the prohibition period.

"But, we believe there is great promise for future changes in these emotions, attitudes, and consequent behavior."

Kids musn't be ignored

SAN DIEGO — The children of alcoholic parents can no longer be ignored, Ernest P. Noble told the annual meeting here of the National Council on Alcoholism.

This population can be estimated at 12 million, said Dr Noble, director of the National Institute on Alcohol Abuse and Alcoholism.

And they are at high risk of becoming future victims of alcoholism themselves, beyond the hurt they suffer today.

He quoted a letter he received recently from one child:

"It is not me who is the person who has the drinking problem, it's my father. I'm just writing cause he's to bull headed to write, or go to any meeting. When he gets drunk he beats me, my mother says she will do something about it, but, she never does. When you get drug, slung against walls, stepped on, then just plain beat its not funny. He tease me, the way I look, I can't help it if I'm ugly. I can't get along with my parents, the only ones I love are my brother and my dog, my brothers in the air force, so I never get to see him. I've thought about killing myself but I scared my dog won't eat. I went to Florida once and she wouldn't eat. I don't know if I'm doing the right thing."

Pot smokers' euphoria, insights — phony

By John Shaughnessy

TORONTO — Marijuana smokers who think a joint puts them in closer touch with other people's feelings are victims of the drug's distorting powers.

In a test of warmth, empathy, and genuineness, subjects intoxicated by marijuana seemed "phonier" than those who smoked placebo. A few marijuana smokers became more communicative, but the researchers from the University of California at San Diego couldn't say why.

David S. Janowsky, head of the research team, told the American Psychiatric Association here his study is among the first to explore interpersonal effects of marijuana.

Anecdotal reports have suggested marijuana intoxication is associated with increased insight, caring, and warmth. Other reports suggested people intoxicated with marijuana are withdrawn and interact less.

To test the hypothesis that marijuana increased empathy and caring Dr Janowsky matched 20 male mental health workers — all occasional marijuana users — with 20 women who played the role of troubled partners. (Only males can be given marijuana experimentally under US federal guidelines. The prohibition against administering marijuana to female experimental subjects stems partly from a fear that such substances may cause birth defects.)

Each subject smoked active marijuana containing 6 mg delta-9-THC, and a week earlier

(See — Pot — page 7)

Inside

Manitoba rejects the idea of raising drinking age

By Manfred Jager

WINNIPEG — The Manitoba legislature has debated a proposal to raise the legal drinking age to 19 from 18, but the suggestion that the move would cut down on alcohol abuse did not carry the majority of the House.

Speakers of both the New Democratic Party government and the small Liberal opposition party agreed during the debate that the dictum that a person of 18 years of age is old enough to make responsible decisions when it comes to voting should also prevail when it comes to the use of alcohol in society.

The use of liquor by 15- and 16-year-olds is nothing new, Russell Doern, the province's minister of public works, told the legislature, but recent conversations with teenagers had convinced him that the extent of the problem is greatly exaggerated.

As evidence of this, he pointed to the fact that Manitoba teachers had voted down a motion to raise the drinking age by a two-to-one ratio at a recent convention.

He said teachers should know the extent of the problem because of their constant closeness to children in their teens.

Liberal spokesman and MLA, Lloyd Axworthy, said raising the drinking age would only be an attempt to solve the problems of a minority of teenagers with drinking problems. To pass the motion and raise the legal drinking age, said Dr Axworthy, would be to label 18-year-olds as a class of people who can't make a responsible decision.

Extending the logic on which the proposal was based, Dr Axworthy said, would mean the Manitoba legislature should also have considered laws prohibiting early marriages because they are most likely to break up, or outlawing alcohol use among people past 65, because of the danger of alcoholism in the latter years.

Instead of raising the legal drinking age, members suggested, a more effective solution to alcohol abuse would be better enforcement of existing liquor laws and education on alcohol. Dr Axworthy suggested identification card as a possible aid to law enforcement.

Another member of the legislature reminded his colleagues that it is legal to become a legislator of Manitoba at the age of 18. It would be ludicrous if the Speaker of the House had to make sure that certain younger members drank nothing but sasarsaparilla at official parties attended by members of the legislature.

In measures to control alcohol dependence

Broader issues must be addressed

BOSTON — Measures to control the increase in alcohol dependence will not be successful if they are undertaken in isolation.

According to H. David Archibald, executive vice chairman of the Addiction Research Foundation of Ontario, such measures cannot be separated from the broader issues of why people use psychoactive drugs in the first place, and the environmental conditions that motivate them to do so.

And just as specific control measures cannot succeed independently, so nations can no longer function in isolation. "It is becoming more and more difficult for individual nations to act independently in trying to influence changes in lifestyle and living habits."

Speaking to the American Occupational Medical Association here, Mr Archibald said "the development of significant public policies in any country must include not only measures to develop better clinics and specialized facilities but also measures to change our environment, so as to make alcohol — and other drugs — less of a necessity, less of a social force, and less integral to our lifestyles, whether business life or social life."

In his view, very few single actions, launched independently of broad social-health policies, have a chance of achieving what their architects intend. "Yet traditionally we isolate trouble spots in our society and attack specific and usually narrow aspects of the poblem.

"We see alcohol use rising among young people and we become preoccupied with manipulating drinking ages. We become upset by rising numbers of alcohol-related auto fatalities and we set up breathalyzer laws and more spot checks. We see more inebriates on the streets of our cities and we increase the number of detoxification centres.

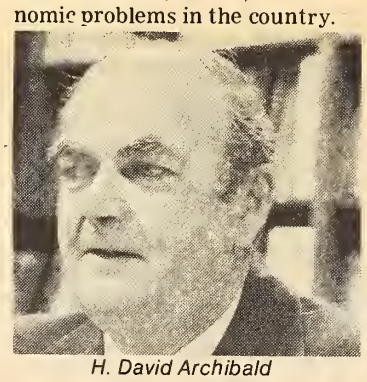
"We concentrate on interrupting supplies and trying to suppress distribution. We marshall as many resources as we can for the development of new treatment techniques and convince ourselves that we are truly managing or controlling the problem."

This approach, said Mr Archibald, manages to keep some of the symptoms of alcoholism in check, but it does little to modify people's own demands for alcohol and other drugs and so the epidemic continues. And the reason is that emphasis on the substance often means two other important components of the problem — the person consuming the drug, and the environment in which the drug is made available and consumed — are neglected.

"In some way we have to convince people that the right to 'choose their own poison' is a dubious right and is not consistent with the preservation of a healthy environment or the reduction of alcohol and drug-related damage. Until people put a higher premium on their lives and on their physical and mental conditioning, we will not see any striking advances in the management of alcoholism."

Any approach to solving or diminishing the seriousness of the health and social problems associated with alcohol and drug use must take into account the drug, the person, and the environment. And with this as a basic premise, Mr Archibald outlined some consequences for program planning:

- Provision of services for the treatment and rehabilitation of drug dependent persons should, whenever possible, be integrated with other health welfare and economic development programs. Moreover the size and nature of the health and social damage from drug use should be assessed within the context of and measured against data on the overall health, social, and economic problems in the country.



H. David Archibald

- A variety of personnel are required in the development and application of programs. While there is need for some specialists in clinical research, epidemiology, and program planning, all classes of health workers should be trained to apply their specific skills and orientation to control and prevent alcohol or drug dependence and treat and rehabilitate alcohol and drug dependent people.
- Internationally, there is now a considerable imbalance of resources, knowledge, and experience in the field of alcohol and drug use and dependence between developing countries and developed countries. Both could profit from a well organized international system for the exchange of information and experience. In most countries the chief necessity is to be able to apply what is already known to particular needs and circumstances.

Pot term was 'cruel, unusual'

WASHINGTON — A man serving a 40-year prison term for possession of a small amount of marijuana has been freed by a federal court on grounds the sentence is unconstitutional.

US District Court Judge James Turk rules that the 1974 sentence on Roger Davis by a Virginia court "is so grossly out of proportion to the severity of the crimes as to constitute cruel and unusual punishment in violation of the Eighth Amendment of the Constitution."

Davis was also fined $20,000. He lived in a small town of Wytheville, Virginia, and was arrested after a police informant bought marijuana from him with money supplied by the police.

While Judge Turk did not challenge the statute governing the sale of marijuana, he questioned the need for a law aimed at stopping "the sale of the questionable harmful drug."

His decision is to be appealed to a higher federal court.

MDs should treat old with high suspicion

ANAHEIM, CA — Sleeping pills, stimulants, and anti-anxiety drugs should almost never be prescribed to older people, says Marc A. Schuckit of the University of Washington, Seattle.

"None of them have been proven to work more than a couple of weeks," he told the recent annual session of the California Medical Association.

Also, "I feel very strongly that there is no reason to prescribe amphetamines to older people. After three to five days, they don't work for weight loss and they certainly don't work for depression or anything else," said Dr Shuckit, an associate professor in psychiatry and behavioral sciences, and also director of the Alcoholism and Drug Abuse Institute.

"The nice little 70-year-old man who comes into your office complaining of headache or depression is a potential drug abuser. Probably one in 10 people over the age of 60 are drug abusers.

"Physicians should have a high index of awareness of the abuse of sleeping pills, anti-anxiety drugs, anti-depressants, and stimulants in older people because it happens frequently."

He said doctors should be suspicious if patients are insistent, for example, on having a sleeping pill, even after they are told that, with rare exceptions, sleeping pills stop working after five days.

Such patients are at least psychologically dependent and could be physically dependent he said. He warned it is easy to tip off an organic brain syndrome in the older drug abuser.

Once drug abuse is diagnosed, Dr Schuckit recommends withdrawal. But, "you must recognize your power is somewhat limited."

He suggested the doctor should let the patient and family know he or she is concerned and suggest to the family that they do everything they can to stop supply at all levels. This may mean the family or the doctor will have to call other physicians and/or pharmacies.

The patient should be warned not to stop taking the drug without a physician's supervision and then should be hospitalized and the drugs withdrawn gradually over one or two weeks.

Doctors should firmly admonish the patient that "I'll never prescribe those drugs for you but you will get all you need to come off them slowly in the hospital."

Marc Shuckit

An ode to restraining the urge to neologize

By Wayne Howell

"THEN FELT I like some watcher of the skies / when a new planet swims within his ken." Thus wrote the English poet John Keats, upon first looking into Chapman's translation of Homer. Now I cannot say that I felt exactly the same emotions when, upon first looking into the April 1977 edition of **The Journal**, I discovered a new verb — lesioning (as a substitute for 'to make or produce a lesion') — but like Keats, I was inspired to put my thoughts into verse. With a little help from a friend . . .

To verbize or not to verbize: that is the question:
Whether tis nobler in the end to suffer
The restraints and rules of Standard English Usage,
Or to take up arms against a sea of nouns,
And by verbizing demean them? To liaise, to concretize,
And more; and by a wanton verbizing to end
The canons and thousand little rules
That English is heir to. Tis not a consummation
Devoutly to be wish'd. To methadologize, to parameterize,
To evidentialize, perchance to paradigmize: ay, there's the rub;
For in that orgy of neologizing what verbs may come
When we have consigned all nouns to verbal toil,
Must give us pause. There's lesionize,
That makes calamity of a virgin noun;
And other bastard children of the noxious craze
To fashion verbs from proud old nouns of noble mien.
Perhaps we should use those verbs we have
Than fly to others that we know not of;
For who shall bear the whips and scorns of Newman,
The tongue's doyen, his erudite contumely,
The rantings of displeased Depoe,
The indignations of Bernstein and the turns
Dead Fowler will make in his eternal grave?
Conscience should make cowards of us all,
And thus the unnatural urge to neologize
Should be restrained with the pale cast of thought
And verbizing exercises without pith or moment
Should be turned awry.

* * *

(Wayne Howell is an Ottawa physician and freelance writer).

Industrial workers are at risk

Chronic alcoholics who face special problems with industrial pollutants must be warned of the dangers and given treatment, says biochemist.

OTTAWA — Alcohol consumption significantly increases the risk of workers being poisoned by industrial chemicals.

Dominique Maestracci, a biochemist at the University of Montreal told Input '77, a conference on occupational alcoholism and drug abuse here, that chronic alcoholics who face special problems with industrial "pollutants", must be warned of the dangers and given treatment.

Frequent exposure to carbon tetrachloride, a chemical commonly used as a cleaning and degreasing agent and in fire extinguishers, can be poisonous even at low concentrations. Dr Maestracci said alcohol consumption enhances the chemical's toxicity.

"Chronic alcoholism or ingestion of alcohol at the time of exposure is probably related to the development of fatal poisoning. The risk of intoxication and organic damage is considerably increased by drinking before, during, or after exposure to the fumes of carbon tetrachloride."

Drinking also increases the toxicity of amino- or nitro-aromatic compounds which can be absorbed by workers by inhalation or through the skin.

"In munitions workers intoxicated by dinitorbenzene, ingestion of even a small quantity of beer leads to serious poisoning even if the alcohol is taken several weeks after symptoms of acute intoxication have disappeared," said Dr Maestracci.

Aniline, used as a dye base in pharmaceuticals and insecticides, is another dangerous chemical. Workers at risk include those using the dyes for leathers, textiles, furs and paper goods.

Dr Maestracci said a single cocktail could be enough to arouse the potentially toxic effects of nitroglycerine. A simultaneous absorption of that chemical and alcohol can change behavior "sometimes to the point of homicidal mania."

Drinking increases the depressant effects of chloroform (trichloromethane) used as a solvent in varnish, floor polish, insecticides, and plastics, and lowers the quantity of the chemical necessary to cause death, he said.

Alcohol also intensifies the effects of poisoning by benzene, used in glue, paint, varnish, rubber, printing ink, engine fuel, wax, and floor polish. Dr Maestracci said the first symptoms of benzene poisoning can appear as late as several years after exposure.

Noting that alcoholic beverages contain lead, he said this could be an important factor aggravating lead poisoning in those working in the many industries where that metal is in use.

Breathing difficulties caused by inhalation of calcium cyanamide, used as a fertilizer and weed killer, "are very visible when alcohol is ingested before during or after absorption of cyanamide," he said.

Drug 'hunger' may represent upset in inborn 'narcotic' substance

Brain opiates may play important role in therapy

By Dorothy Trainor

MONTREAL — The discovery the brain contains its own opiate-like substances may help researchers to produce a non-addictive treatment for drug abuse.

Research on these natural opiates (endorphins and enkephalins) began with the discovery of a pain-killing substance in the brain of a pig and the determination it had been produced in part, or in total, by the pituitary gland. Other animal studies led to the finding these substances, cerebral peptides, are concentrated in the pituitary and mid-brain as well.

"It has been known for some time that some animals produce their own painkillers, but we were the first to prove the endorphins occur in the human pituitary," according to Michel Chretien, head of a three-man research team at the Clinical Research Institute of Montreal.

"They have now been found throughout the brain, but they are particularly concentrated in the pituitary," he said.

From the beginning of the animal research, Dr Chretien said, identification of these brain peptides has had important implications for future research.

It has been found the substances dubbed 'endorphins' and 'enkephalins' link naturally to receptor sites in the brain. These receptor sites had previously been isolated and characterized by the fact that chemical agents, including narcotics, combine with them. A question was: Why are narcotic receptors in the brain?

"It's unlikely that nature provided receptor sites for people to become drug addicts," Dr Chretien observed in an interview with **The Journal**.

Dr Chretien and his colleagues, Drs Martin Lis and Nabil G. Seidah, have been studying the nature and effects of substances produced by the pituitary gland for nine years. This work led naturally to their research on endorphins. Parallel work has been going on in the United States, Britain, and Canada.

Michel Chretien

"Investigators now believe the endorphins have the same receptor sites in the brain as morphine and other analgesics. We want to find out how this substance works and whether endorphin can replace morphine or replace it in part so that smaller doses would be needed by the addict."

But these possibilities lie in the future. The endorphin analogues have to be produced. It has to be demonstrated that such an analogue is non-addictive when administered from outside the body.

Research at the Clinical Research Institute of Montreal, and in othe laboratories, determined the chemical structure of these peptides as being chains of from five to 31 amino acids. Enkephalins are chains of five amino acids with their action being more short-lived, while endorphins have up to 31 amino acids. Just how important these investigations are can be demonstrated by work carried out concurrently at the Institute and at the Salk Institute in La Jolla, California.

Scientists isolated endorphins from sheep and injected the substances into rats, with a resulting dramatic modification in the rats' behavior. The alpha-endorphin exercised a tranquillizing and light analgesic effect. The gamma-endorphin provoked the contrary — extremely aggressive behavior. The beta-endorphin had a cataleptic effect within several hours. The rats who had been rendered cataleptic were then given an opiate antagonist, naloxone and were restored immediately to normal component.

But such studies raise other questions:

"Could the level of this brain opiate have something to do with pain tolerance?" said Dr Chretien. We used to say that when an individual's pain threshold was high he had a strong mind or was tough. Maybe what was really happening was that the person's pituitary and brain analgesic was doing the job."

Other researchers say the endorphins have research possibilities with respect to the comprehension of schizophrenia and other psychiatric conditions.

Bruce Pomeranz, professor of neurobiology at the University of Toronto, has added yet another dimension to this research. He has suggested through his studies of electrical signals in cat spinal cord cells that *acupuncture* releases endorphins in the pituitary or mid-brain and thus reduces pain. Although he said this hypothesis requires more research for validation, he has tested it by injecting naloxone (known to be an antagonist to morphine and shown to be an antagonist to endorphin) and succeeded in preventing the production of analgesia by acupuncture.

The following hypothesis for acupuncture analgesia has been proposed by Dr Pomeranz:

"Needling activates deep sensory nerves which cause the pituitary (or mid-brain) to release endorphins. These endorphins block signals from getting through the nerve chains in the pain pathway carrying messages from spinal cord to the higher brain centres."

If further work can bear this out, obviously acupuncture could become much more widely accepted and would be directed by more precise principles. Dr David J. Mayer of the Medical College of Virginia at Richmond, has tested the effects of acupuncture in humans in a way that has supported Dr Pomeranz' theory.

It adds up to intensive research. As Dr Carl Pinsky, department of pharmacology and therapeutics, University of Manitoba, told an Addiction Research Foundation conference: "Evidence is accumulating that a hierarchy of endogenous opioids exist within the normal brain and plays a physiological role in behavior and in autonomic function. We may expect important therapeutic applications to rise from this work in the near future.

"Neurotransmitter function in the brain is definitely altered by opiate narcotics, but there is a controversy over which neurotransmitter system is primarily affected by these drugs.

"Much future work is needed to establish a means of preventing the very persistent drug craving which remains after acute narcotic withdrawal ... Since pituitary hormones are known profoundly to affect appetitive activity, the drug 'hunger' may very well represent an upset of this remarkable inborn 'narcotic' substance."

Teenage alcoholism far from new

NEW YORK — Alcoholism among teenagers, especially members of the minority communities, has been around for years.

"But until recently, society has not chosen, or has been unable, really to put teeth into the problem or take a look at it," according to Andrew Abrahams, Downstate Medical School, Brooklyn, New York.

Dr Abrahams told a workshop at the American Orthopsychiatric Association conference here that adolescent drinking is the result usually of one of three factors: use of alcohol to cover a psychological disturbance; simple experimentation; or the adolescent is in fact an alcoholic.

Studies in the New York school system have shown the majority of teenagers drink because of peer approval. Many said they drink also because they are unable to relate to adults or they need courage.

Dr Abrahams said he found those reasons disturbing and they indicate to him "you are dealing with an inadequate personality who is unable to utilize defence mechanisms, and who has a low-frustration tolerance."

Dr Abrahams said he suspects such inadequacies, again under the guise of peer approval, are the reason for much of marijuana and hard drug use as well.

In the black teenage population, excess use of alcohol, he believes, is the result of personality and character disorders.

Dr Abrahams continued: "If alcoholism is indeed a manifestation of an inadequate personality, one has to elaborate the treatment scenario so that it reorganizes and rehabilitates this inadequate personality.

"It becomes more difficult when dealing with blacks, and I think this may apply to Hispanics and also, for different reasons, with women, as the treatment team begins to make that personality adequate again.

"There is a whole host of external societial factors that keeps reinforcing that the personality is indeed really inadequate."

Manipulation among black teenagers under treatment is very clever, subtle, and difficult to deal with. "As the black personality develops, one of the things it has had to learn, in order to survive, is to become an expert manipulator."

Dr Abrahams said he thinks the best way to deal with the alcohol problem among teenagers is through the school system. "Probably there is no other mechanism available."

Men drink, women snack

WASHINGTON — When under stress, men are more likely to smoke and drink, says a John Hopkins professor, while women tend to have a snack or a soft drink.

"Clearly women have been given greater social encouragement to acknowledge stress and emotion," says Lawrence Green of the Johns Hopkins School of Public Health.

"Men have been given more encouragement to sublimate or disavow stress."

In a recent study he found that women under stress will cry, scream, pray, read, watch TV or consult a doctor or minister.

But men just drink or smoke.

Too often this means that men let their tensions rise until the inevitable explosion occurs.

Help programs for employees a male domain

OTTAWA —Employee assistance programs for alcoholics may be discriminating against women.

Most addiction workers who help industry set up policy and education programs are men, says Lavada Pinder, director of the Ottawa-Carleton Centre of the Addiction Research Foundation of Ontario. Their thinking is centred on male alcoholism.

"It would take a real effort to build in an equal emphasis on women," she told Input '77, a conference on occupational alcoholism and drug abuse here. "There are few women in sufficiently responsible positions to insist on this."

Ms Pinder said there is little research documenting the nature and extent of alcoholism in the workplace, the number of employees identified, referred for help or consequent treatment outcome. "Research dealing with any of these factors as they relate to women is virtually non-existent."

One reason for this may be that two highly charged issues are at stake — women working and women drinking. "Either of these, by itself, is capable of causing responses ranging from hostility to empathy," said Ms Pinder.

Most studies on alcoholism in women have focused on drinking housewives, largely because of the effect these women may have on their children and husbands, she said. "But 33% of married women are employed full-time and may be as subject to alcholism as their sisters who are homemakers."

Lavada Pinder

Ms Pinder said society has always come down hard on alcoholics and even harder on alcoholic women so family, friends, physicians, social workers, and employers have all collaborated with the alcoholic woman's efforts to cover up.

She said doctors often mistakenly diagnose alcoholic women as emotionally ill, prescribing mood changing drugs, such as tranquillizers and, in effect, contribute to multiple addictions.

Called 'clear' hazard

Schizophrenics should avoid cannabis

TORONTO — Marijuana use, even in moderate doses, presents a clear hazard to schizophrenics.

While marijuana can perhaps be used safely by many people, patients who are psychotic, irrespective of etiology, run the risk of relapse and exacerbation of an otherwise well-controlled illness by use even of moderate amounts of marijuana.

Darold Treffert says cannabis use — acute intoxication or long term abuse — has been reported to produce in some people psychotic episodes with either toxic mania and depression or paranoid features. He admits that there is controversy as to how sizable the number of such cases is, what the dose relationship is, and whether marijuana merely precipitates psychosis in an otherwise predisposed person or is truly causal.

However, based on his experience as director of the Winnebago Mental Health Institute in Winnebago, Wisconsin, Dr Treffert is convinced that schizophrenic patients should avoid marijuana.

Speaking to the American Psychiatric Association here, Dr Treffert described four cases where the use of marijuana as the independent variable produced a serious exacerbation of the psychotic process in an otherwise well-controlled illness. In two cases, the relapse and deterioration was prolonged and severe, one case involving serious self-mutilation, the other severe, aggressive acting out requiring care in a maximum security hospital.

Dr Treffert said in each case the patient served as his own control in that the sole substance used was marijuana, and each time marijuana use at moderate levels began there was exacerbation and deterioration. Abstinence from marijuana led to improvement and stabilization.

Each of the four patients has become convinced through persuasion and his own observation that marijuana use is clearly correlated with the recurrence of psychotic symptoms. As a result, each abstains from marijuana use, and Dr Treffert said in each of the four patients, even in those with the most protracted course so far, the remission has been sustained so long as the patient abstains from marijuana.

He noted however that during rehabilitation, there is a temptation on the patient's part to use marijuana to deal with the depression frequently seen following a major psychotic episode. There is also a temptation to use marijuana in order to re-establish better social relations, particularly if the patient, prior to hospitalization, was involved in a peer group where marijuana use was frequent and usual.

"In that sense, both with problems of depression and problems in re-socialization, the schizophrenic has a heightened interest in the use of marijuana even in the face of the special risk that marijuana presents."

The schizophrenic patient needs to learn that while marijuana use perhaps may be safe for some persons, he or she is not one of those persons, concluded Dr Treffert. "The schizophrenic patient needs to be alerted to the special hazard marijuana use has for him or her in the same manner as we alert other patients to possible untoward interactions between their illness and substances they may use.

Coffee should have 'damaging to health' labels

By John Shaughnessy

TORONTO — Recent increases in the price of coffee may be a blessing in disguise.

The hazards of caffeine are such that there may even be a case for putting warning labels on coffee packages that read "Drinking more than eight cups a day is damaging to your health."

A panel discussion on caffeine and psychiatric symptoms, held in conjunction with the American Psychiatric Association meeting here, revealed that coffee affects different people in different, sometimes totally opposite ways.

John Greden, associate professor of psychiatry at the University of Michigan Medical Center, Ann Arbor, listed 17 commonly reported symptoms of caffeinism, including nervousness, irritability, agitation, yawning, fatigue and lethargy, insomnia, ringing in the ears, occasional muscle twitching, rapid breathing, headache, heart palpitations, stomach pains, nausea, and flashes of light seen by the eyes.

Excessive caffeine can produce rapid or slow heartbeat in different people. It may also produce depression, or it may be that depressed people drink a lot of coffee to try to overcome their depression.

Dr Greden said although few, if any, medical reports exist on caffeinism causing depression, more high caffeine users among psychiatric inpatients scored high on psychological tests designed to detect depression. The higher the caffeine intake, the higher the scores. People who ingested more than 750 mg a day had scores more than twice as high as those who took less than 250 mg of caffeine a day.

Another panelist, Richard Gilbert, said research on caffeinism in the general population is difficult and produces imprecise data because most of it is based on questionnaires asking people how many cups of coffee, tea, cola drinks, or other caffeine-containing foods they use. The amount of caffeine varies widely so total consumption gives only a rough guide to actual caffeine content.

A cup of coffee can range from 30 to 180 mg of caffeine. Filter coffee usually has about 100 mg of caffeine, percolator coffee a little less. Caffeine content in a cup of tea can vary from 10 to 100 mg. In a raw state, tea has more caffeine than coffee, but it has less in a cup because it is made in a less concentrated way. In North America the average cup of tea contains about 30 mg of caffeine.

The legal maximum for a 10-ounce can of cola is 55 mg, but the usual caffeine content is about 35 mg.

Dr Gilbert, a scientist at the Addiction Research Foundation of Ontario, said about one quarter of the population takes more than 350 mg of caffeine a day, but there is little evidence of health damage under 600 mg. However, he said heavy users become so accustomed to their caffeine that they suffer withdrawal symptoms such as headaches when they stop.

There is also evidence from people tested in sleep laboratories that caffeine interferes with sleep even when the individual believes it does not. It may make getting to sleep harder, reduce the proportion of deep sleep and cause more sleep disturbance.

Richard Gilbert

Interestingly, for some people irritability, drowsiness, lethargy, nervousness, and depression may be caffeine withdrawal symptoms even though they are also listed among symptoms caused by caffeinism.

Dr Gilbert said there is some evidence that coffee may be a co-carcinogen, predisposing to cancer when acting with other chemicals. He also noted that caffeine's chemical structure is so similar to part of the genetic code that it may affect cell reproduction.

It can also influence the reproductive system in animals. Male hampsters, fed high doses of caffeine before breeding, have more female offspring, a ratio of 65 females to 31 males compared to the usual 49 to 51.

State will take liquor-laced candy away from children

SACRAMENTO — Liquor-laced candy, which became a rage with youngsters in San Francisco and Los Angeles in recent months, may soon be a thing of the past.

Candy makers have just been told by the state legislature to stop putting liquor in confections or to refrain from selling them to minors.

The controversy arose because of the test marketing of a 25-cent mini-cake called Babarum, billed as the candy with the mellow taste. Children took to the new confection instantly, some bragging it was the only legal way they could get their ration of liquor and ordering their Babarum candies "by the shot."

That was before Assemblywoman Leona Egeland (Democrat-San Jose) became interested in the wisdom of children eating alcoholic candy.

Ms Egeland disclosed that investigation revealed samples of the controversial candy contained about 6% alcohol.

"To think that any child can purchase sugar-coated alcohol disguised as cake is unthinkable" she said.

The bill she proposed was passed 8 to 0 by the Assembly Governmental Organization Committee. The "urgency" legislation outlaws the sale of candy, gum or small cakes with an alcohol content greater than one-half per cent by weight to anyone under 21.

The bill will go into effect whenever it is signed by Governor Brown.

'Chemistry, not psychology'

Chemical factors spur alcoholism

WEST LAFAYETTE, Ind. — A Purdue University investigator has uncovered evidence indicating that alcoholism is linked to chemical factors and not psychological and social ones.

Robert Myers, director of Purdue's neuropsychology laboratory, found that injecting a metabolite of alcohol — tetrahydropapveroline (THP) — into rat brain increases its alcohol consumption by as much as 20 times.

And even when THP infusions were stopped after 12 days the rats continued to take as much as half their daily fluid intake in alcohol up to six months later.

Dr Myers said this is the first time anyone has been able to induce an animal that ordinarily despises alcohol actively to seek it out and drink it.

"THP seems to be a likely candidate for a key role in addiction," Dr Myers said. THP is found in the opium poppy and is a precursor of morphine. It has also been produced in laboratory cultures of brain tissue.

Normally THP never finds its way into the brain or into areas of the brain where it could trigger addiction, said Dr Myers. He reasons it is possible that the alcoholic has a cellular defect in his brain that may cause an abnormal formation of THP.

Pipes, cigars, cigarettes

No choice for smokers

EAST ORANGE, NJ — Although pipe and cigar smokers were once considered at less risk of heart disease than cigarette smokers, a new study suggests this is not so.

The stages of heart disease in 1,056 men were determined after death and compared with their smoking habits in the study by Dr Oscar Auerbach of the VA Hospital in East Orange, NJ and Dr Harry W. Carter of St. Barnabas Medical Center in Livingston, NJ.

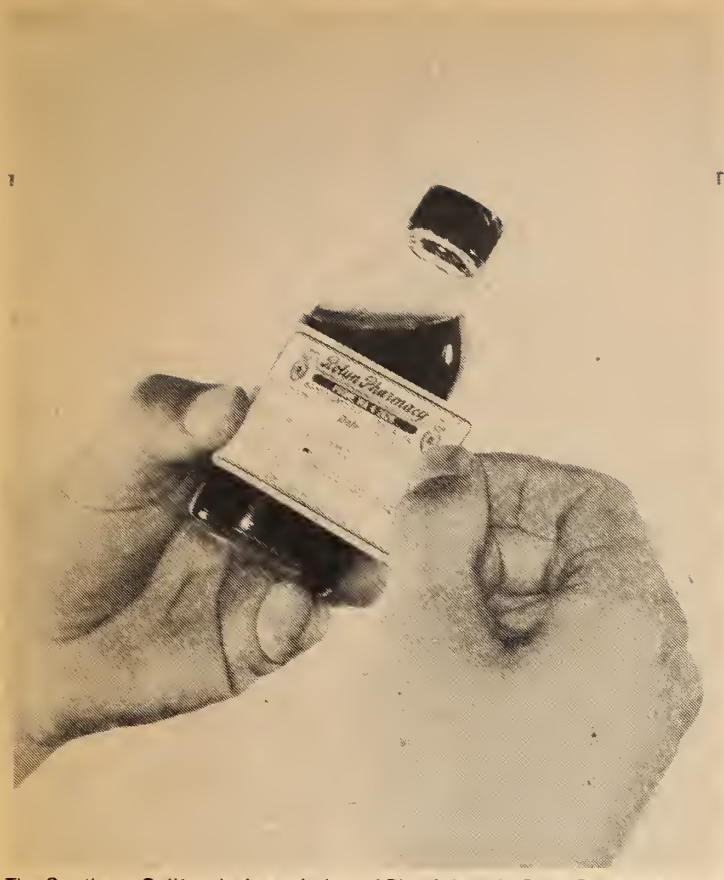
"The proportion of cigar and pipe smokers who had moderate and advanced atherosclerosis was about the same as those smoking one or two packs of cigarettes per day." they report with two American Cancer Society epidemiologists in the journal *Chest.*

Non-smokers gain ground

BERKELEY, CA — A comprehensive new ordinance will ban smoking in most indoor gathering places here beginning in July.

The law will prohibit smoking in all retail stores, government assembly rooms, public transit vehicles, waiting rooms and hotel and motel lobbies.

Violators will be subject to "infraction" citations carrying potential fines of $50.



The Southern California Association of Physicians in Drug Dependence is trying to drive out fellow professionals who make fortunes selling prescriptions to addicts.

California puts the heat on pill-pushing 'script' doctors

By Harvey McConnell

LOS ANGELES — A small group of doctors expert in drug use and abuse is the key factor in driving out fellow professionals who make fortunes selling prescriptions to addicts.

The Southern California Association of Physicians in Drug Dependence is just over a year old and limits membership to those who deal with drug abuse on the clinical level. Yet its 25 members are overwhelmed with requests.

The main aim of the association is not the script doctors, although this is what has brought it most prominence, according to Forest Tennant, its chairman.

"Our first and foremost aim is to exchange professional information about how you treat drug dependent people. This is something that has really been lacking for physicians."

It is the emphasis on appropriate prescribing and treatment that leads to the script doctors.

Dr Tennant says: "The kind of physicians most people think of when they think of script doctors is the man who tries to make all of his patients feel good by giving them a little diazepam or something else.

"What we do to keep the physicians from prescribing these drugs, I don't know.

"The ones we have been able to do something about so far, and we plan to do more about in the future, are the real script doctors. These are physicians who are making a living, and it can be easily $500,000 a year, by prescribing Schedule two or three drugs.

Forest Tennant

"Some of them are writing hundreds of prescriptions a day. Medicine means nothing. They are just out to make a buck."

It is estimated there are several dozen script doctors in the Los Angeles area alone. They charge about $10 a prescription for 50-100 tablets of a particular drug.

The major problem in the past, Dr Tennant adds, "has been a great reluctance on the part of the judiciary and the public to convict a physician."

Because the reporting system is not that specific, it takes flagrant overprescribing by a doctor to receive any sort of notice.

It was this situation that prompted Dr Tennant and Thomas Ungerleider and Joseph Shannon, both psychiatrists, to form the association.

Dr Ungerleider, associate professor at the University of California at Los Angeles, explains the frustrations: "I'd write to the local medical society and say I had received some 18 complaints about Dr So and So, that he was giving drugs that were being resold, and could it please be checked for me.

"They would write the doctor saying: 'Dr Ungerleider says you are a script doctor. Are you?'

"They would write back to me: 'He says he is not a script doctor.' That would be the end of it."

Fortunately, US federal law is tougher than California state law and with the cooperation of US attorney William Hawes, the script doctors are being taken to court.

Those found guilty have been subject to heavy fines and their right to prescribe withdrawn.

Although members of the association break one of the unwritten rules of many professions — you don't testify against your own — in this situation most doctors are happy to see the script doctors being brought to court.

Dr Tennant says when any association member goes to court: "We don't say he is a bad guy. We will take the medical texts and documentation and show that this is how a patient should be treated for a particular complaint.

"A script doctor's defence is always that the patient said he could not sleep, or was depressed, and that is why he prescribed these drugs.

"We don't say that this doctor is out there feeding drug abusers or creating problems on the streets, or trafficking.

"We point out the proper way to treat someone with insomina, depression, or anxiety, and that way is not with very abusable substances, except in rare instances."

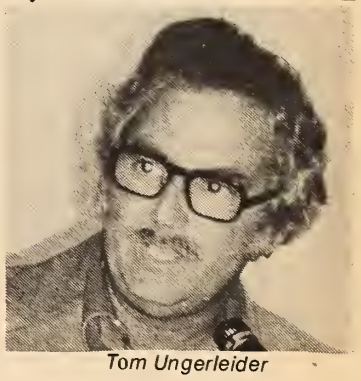
Dr. Ungerleider points out: "We don't testify in all cases and I guess we could be criticized in that we decide in our own minds how bad that person is. But if he is a senile doctor who doesn't know what he is doing, we recommend that he just be warned."

Dr Tennant says: "You have to draw a very fine line between the issue of good sound medical use of drugs and abuse potential. We don't want to see the medical profession reach a point where doctors may be supressed from treating patients according to real medical need.

"For example, barbiturates have some good sound medical uses, as do amphetamines at times.

"This is why we have to get the medical profession to look at prescribing as rationally as possible and to try and get the best therapeutic use out of those drugs that do have abuse potential."

The major problem the association has is demands for service by its members.



Tom Ungerleider

Dr Tennant adds: "We are overwhelmed with requests for all kinds of things, from consultations to testifying in court, to developing publications, to speaking to law enforcement agencies and civic groups."

Doctors perfect targets for addicts

PHYSICIANS are often inviting targets for drug addicts and dope peddlers wishing to have a "prescription" filled.

Any physician is fair game. If he's a new doctor in town, he's especially vulnerable, and if he happens to practise in a resort that's normally bustling with transients, he's the perfect target, says Duane A. Lawrence.

After being duped himself a number of times, Dr Lawrence developed a check list for dealing with unfamiliar patients requesting prescriptions.

Writing in the March 21 issue of *Medical Economics*, Dr Lawrence suggests that physicians:

- Watch out when a new patient asks for a specific drug, and sense trouble when a patient tries to talk you out of the drug you've just prescribed, only to ask for something stronger. Also, don't give a transient the requested maintenance pain drug on the first visit. Patients with a genuine need for such drugs usually have the foresight to bring enough with them on their trip.
- Check back on previous prescriptions. The drug abuser often will give phoney names of doctors, hospitals and pharmacists in other areas and count on the physician not to check.
- Suspect all stories of lost prescriptions. The addict may return early for a repeat prescription with the story of pills pushed down the toilet, stolen from his car, or inadvertently sent to the laundry with his shirts.
- Beware of the transient who keeps coming back once he's obtained a prescription from you. Vacations or mother's funeral don't last forever.
- Have your staff alert you to possible phonies. The abuser acts a role when he's seeing a doctor, but in the waiting room his guard is down.
- Insist on seeing the patient who wants a refill. In order to make their pretended plight more believable, or hide their withdrawal symptoms, drug abusers often send a "relative" to pick up a refill for them.
- Keep complete records and consult them. Record the number and strength of tablets dispensed and check the record before giving refills. Record tales of woe, so the abuser can't use the same story twice. The records will help if you're charged with conspiring to provide drug abusers with illicit drugs.
- Answer telephone calls from the pharmacist yourself. If you don't come to the phone when he calls your office and an employee OKs the prescription, you may find yourself later answering to some investigatory body. The pharmacist may suspect a patient with a legitimate prescription from you if he's also seeing several other doctors and obtaining drugs from them.
- Make your prescriptions alteration-proof. The numeral 30 can be changed to 80, so write "30 (thirty) tablets". Write "No (none) refills". The "no" can be changed to "two".

NB majority votes yes on right to breathe clean air

FREDERICTON, NB — Both smokers and non-smokers agree on at least one thing here — that's the right of those who don't indulge in the habit to breathe clean air in enclosed public places.

The New Brunswick Council on Smoking and Health polled 631 residents of the province on their smoking habits. Almost 80% of the respondents (both smokers and non-smokers) felt health organizations should take a more active role in protecting the rights of a person to breathe air unpolluted by cigarette, cigar, and pipe smoke. A greater percentage of women than men found tobacco smoke offensive, according to the study, and 38.7% of current smokers said they found tobacco smoke offensive. Seventy-six percent of respondents said they were concerned about the effects smoking has on other people, and 80.8% felt smoking should be prohibited on public transportation and in enclosed public places.

Some other findings of the study, which was financed by the Non-Medical Use of Drugs Directorate, were:

- A greater proportion of male and female French speaking respondents are current smokers compared to their English counterparts.
- Almost 65% of respondents who had ever smoked have tried to stop, but less than half have been succesful. Those 45 years of age and older have had the best success rates in giving up smoking.
- Females aged 15 to 20 have the highest smoking rate among women.

Stephen Chappell, co-ordinator of the Council, told **The Journal**, municipalities in the province don't have the right to govern smoking in public places.

"We want to get the municipalities to the point where they can have the power to enforce non-smoking in public places," he said.

Stephen Chappell

Child abuse is seen in addicted families

NEW YORK — Physical abuse of a child has been found in 13% of families with an alcohol or opiate addicted parent that are being studied by the Washingtonian Center for Addictions in Boston.

However, in a report to the conference of the American Orthopsychiatric Association here, investigators emphasized it is difficult to classify this figure as either high or low.

There is little reliable data on the incidence of child abuse in other groups or families in the general population, or in other high risk groups.

Overall, it is clear child abuse does not occur in many families with an alcoholic or opiate addicted parent, the report said.

In the ongoing study of 78 families, the majority have an opiate addicted parent. Most of the alcoholics are male and most of the opiate addicts are female.

James MacDougall, PhD, said it is the researchers' impression that the men may avoid abuse or neglect of the child by withdrawing from the parenting role.

Since the woman still carries much of the family responsibility she may find more difficulty in avoiding abusing the child while impaired.

They have found that many of the alcoholic fathers recognize the potential for physical abuse of children when they drink and they make a deliberate decision not to discipline while drinking.

They either leave all the discipline to the wife, walk out of the house, or ask the children to leave the room. However, they may verbally abuse the children.

At the same time, the men claim their wives risk abuse from them when they drink and physical violence is more difficult to avoid.

The report said it is difficult to give prescriptions for treatment for abuse and other aspects of child care in the families.

One encouraging factor is that the parents are eager to participate in the study and vitally concerned about their children. They felt also their treatment neglected to give them an opportunity to discuss the care of their children.

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In addictions field, it's still an exclusive club

Stamps carry messages in miniature to millions

By M. W. Martin

POSTAGE STAMPS are now being recognized around the world as effective mini-aides to public education. But the countries using stamps to comment on abuse of alcohol and other drugs still form rather an exclusive club.

The eight-cent stamp issued in 1971 by the United States postal service to publicize prevention of drug abuse, was a giant step forward — it was the first drug abuse stamp issued by a major nation and represents 130 million education miniatures aimed at the public (1).

In ordering issuance of this stamp, the US finally joined the club that began in Finland in 1953 with the issuance of the first anti-alcohol stamp.

Only about a dozen governments have ever issued a stamp to combat drug abuse as opposed to alcohol abuse. Stamp catalogues disclose about 20 such stamps — a small number considering some 80,000 pictorial stamps have been issued around the world just in the past 20 years.

Only two other major governments have issued stamps aimed at preventing drug abuse — Italy and the United Nations. In 1964, the UN issued two — one in English and one in French — to honor international efforts and achievements in narcotics control. The design depicts a poppy seed pod and hands (2).

In 1973, the UN again issued commemoratives for the "Stop Drug Abuse" theme. These were in three denominations, all in the same design. Two of the stamps were in cents and for use at the UN's world headquarters in New York. One was in Swiss Francs (centimes) for use at the UN's Geneva offices. The design, a skull superimposed on a poppy, is the work of Australian designer, George Hamori (3).

The most spectacular drug abuse stamp (4) was issued by Austria, in 1973, and is a deserved credit to the Austrian State Printing Works in Vienna, famous for their outstanding stamp designs.

The stamp is a two-schilling value, in striking shades of blood-red: it combines color inks and techniques of printing entirely beyond the range of most postal printers. The design shows a woman's face, with the right side and right eye bearing a "stoned" look; the left side is a skull with eyeless socket. The German inscription above the design reads "Stop! Addiction is suicide."

Surprisingly the country with the most drug abuse stamps is the tiny Principality of Monaco which, in 1972, opened a postal campaign on drug abuse with a two-year scheduled series of 12 designs. Of those, three have appeared, one in 1972 (5), and two in 1973 (6,7).

In June, 1973, the Republic of China (Formosa) joined the list of nations participating in the postal war on drug abuse by issuing a stamp in honor of Lin Tse-hsu (1785-1850) (8).

After a century of futile attempts by the Chinese to halt the importation of opium, on Dec 31, 1838, the Emperior in Peking dispatched Commissioner Lin to Canton; his actions astonished the world.

Arriving in Canton early in 1839, Commissioner Lin began operations by confiscating all opium which he found on foreign ships in the ports of Kwangtung Province, as well as the contents of the Hong warehouse — consisting of more than 20,000 chests.

Then, on June 3, 1839, Lin proceeded to burn a huge quantity of opium. As a result, June 3 is now observed as Opium Suppression Day in China. Lin further demanded the surrender of all opium stored in Western ships and, to insure compliance, he held the Western ships in Canton. When the opium was surrendered, the detained ships were released. This new bold approach, which was a blow to Western prestige and profits, resulted in great tensions and led to the infamous struggle known as the "First Opium War."

All other stamps in this field have been aimed at alcohol. The most unusual stamp to combat drink, and well-known to stamp collectors as a unique design, was issued by Turkey in 1956 to publicize the 25th International Anti-Alcoholism Congress at Istanbul. The design shows hands holding a bottled serpent (9).

The world's first anti-alcoholism stamp, however, was issued by Finland on January 27, 1953, to commemorate the centenary of the temperance movement in that country (10).

Another was issued by Norway in 1959 to commemorate the centenary of the founding of the Norwegian Temperance Movement and to honor its founder Asbjorn Klöster, who started it in Stavanger, Norway (11).

Two recent anti-alcoholism stamps are public education stamps and each forms part of a set of stamps issued to publicize traffic safety. The one from West Germany (12) shows a bottle of whisky and a shot glass, with an auto upside down underneath, a position in which the car is very likely to end if the driver drinks.

The other stamp is from East Germany, DDR, and it shows a perfect combination: a glass of beer, a motorcycle, and an ambulance. The inscription is even better, telling a tale often told but seldom heeded: "Even one glass is too many." (13)

Another recent anti-alcoholism stamp was issued by French Polynesia on March 24, 1972, and is a 20 Francs value. The design, by Therese Roscol, depicts victim imprisoned by his own vice (14).

Personalities associated with temperance movements have also been honored by various nations. One of these is Susan B. Anthony, a well known temperance supporter, who first appeared on a US stamp in 1936. It was issued in her honor in connection with the 16th anniversary of the ratification of the 19th amendment granting suffrage to women (15).

Another American personality honored with a stamp was Frances Elizabeth Willard, who appeared on a 1940 stamp in the series of Famous Americans (16). A leader in the temperance movement, she was president of the national Women's Christian Temperance Union 1879-1898; in 1891 she was elected president of the world WCTU; and in 1882 she helped organize the Prohibition Party.

Other stamps issued for anti-alcoholism personalities include one for Susanna Orelli, who is on a 1945 stamp of Switzerland (17). She was a Swiss feminist, temperance leader, lecturer, and writer. In 1894 she founded the Society of Zurich Women for Non-Alcoholic Restaurants, and was its president in 1894-1913.

In 1938, Ireland issued a stamp to commemorate the centenary of the Temperance Crusade by Father Theobald Mathew. He was an Irish Roman Catholic priest (1790-1856) who inaugurated total abstinence movement in 1838 (18).

Another stamp is from Cuba (19) and it shows Felix Francisco de la Concepcion Varela y Morales (1788-1853), a priest, philosopher, teacher, and author, and also a well-known temperance advocate.

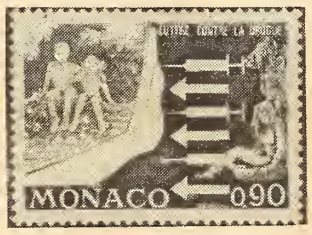
A member of Spain's *Cortes* (Legislature) in 1822-1823, condemned to death when monarchy was established in Spain he fled to New York, in 1823. He then went to Philadelphia and, in 1825, returned to New York, where he became rector in a Brooklyn church. He died in Florida and is buried in Havana.

This article would not be complete without mention of the world's most popular drug of choice — tobacco.

Many stamps have been issued to promote it, but only one has been issued to condemn it.

That one is a fairly rare Polish postal card (only 100,000 issued) of 1971 (20). The imprinted stamp shows a cigarette smoker blowing smoke though his head and the cachet printed in the lower left corner of the card shows a match and a cigarette separated by words "Don't Smoke." Above is a clever couplet, which can be freely translated as "You smoke, you pay/ You throw your health away."

(Mr Martin is a well-known writer on philatelic subjects, having composed more than 400 articles and columns for popular magazines, trade and professional magazines, and house organs in the United States, Canada, England, South Africa, and New Zealand. He has also published two books in the medical field — Let's Talk about The New World of Medicine, and Miracles in Medicine).



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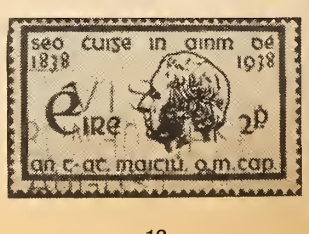

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Disease label permits cop out for alcoholics

DENVER — Labeling alcoholism a disease allows many alcoholics to cop out on the real reasons for their conditions and blocks reeducating many people to drink socially.

John Luce, doctor and author, believes society should "forget about trying to define alcoholism narrowly, and forget about trying to fit it into some disease category.

"Be as broad and indefinite as you can and call it problem drinking. Then, because you do that, you treat everyone who thinks he or she has a problem with drinking."

Dr Luce knows the issues he and Richard Shore, a psychiatrist in San Francisco who specializes in alcohol problems, run counter to the dogma held fervently by many people in the field.

"What we do is ask people to look at themselves, because people create their own problem," Dr Luce adds.

"In psychotherapy, for example it's nice to think about how you were as a child and how it reflects itself in your adult behavior.

"But, if you go so far as to say 'I am what I am today because of that and it is their fault,' you don't advance at all."

He believes "the more you label something a disease, the more you allow the person who has that disease to think he or she is not responsible for it.

"Maybe, and no one has proven this, it dilutes a person's sense of responsibility and gives them an excuse for their behavior. I am not sure this is true, but I think that in some cases it is."

A good example is a patient who says: "I can't help myself, doc, I am an alcoholic."

Dr Luce: "On the one hand that is right, and it prompts me as a doctor to say 'I agree with you, I will take care of you,' which is good, socially speaking.

"On the other hand, if that person really believes it down to the soles of his feet, in a way he is giving himself a cop out, and I think that is a problem."

Dr Luce, co-author with Dr Shore of the book, *To Your Health* finds it easy to expound his ideas in print. For three years he was a speechwriter for California Governor Pat Brown in the 1960s and was later editor of *San Francisco* magazine and a regular contributor to *Look, Esquire*, and *Rolling Stone* before he decided to become a doctor.

John Luce

He has had a long interest in the problem and decided to write the book collaborating with Dr Shore, who, in addition to being in private practice, is a clinical professor at the University of California in San Francisco with many years of experience in treating alcoholism and substance abuse.

Dr Luce said he and Dr Shore feel a new look is needed at the whole problem. They review the current literature and look at the past role of alcohol in many societies.

They provide also their controversial ideas.

Dr Luce points out that calling alcoholism a disease throws the prestige of the medical profession behind the concept and it becomes legitimate for doctors to treat it.

"But, if you take a view you must be a little more specific, and say there has got to be some kind of agent that causes the disease, then it is more difficult to define alcoholism as a disease."

By applying a disease label "in a way it becomes not the fault of the person who has the disease. This is particularly true when you call a disease an infectious process, or metabolic process, or genetic process, or an environmental process.

"It shifts the onus from the individual to something else, and that has tremendous advantages."

The disease label has removed from alcoholism the old stigmata of sin and crime. But it leads to the cop out.

Dr Luce continues: "If you look at alcoholism today as a process that causes social and personal harm, there is nothing in that that has a disease to it.

"If you take the idea that alcoholism is a preordained disease, this reinforces the idea it is not your fault.

"But, if you take the idea that if it is a disease *and it is your fault you got it and it is now out of control*, then that is something I can buy."

Alcohol can produce physical dependence, biological changes, and a withdrawal: but this is true also for most people in regard to cigarettes, or heroin, or almost any other drug.

Dr Luce says he appreciates the psychological power in the disease concept and the argument that an alcoholic must not drink again.

"But I don't believe it is immutable, and I believe alcoholism, if it is a disease or not, can be 'cured.' I believe people can learn how to drink in a different way."

Techniques will be developed ultimately to allow more and more people to practise controlled drinking. "I think you have got to create the right intellectual climate for that, however."

At present no one knows the variables that will allow a person to become a social drinker. In part, it depends on what it is believed excess drinking is due to.

The new tools developed to treat the problem will require more than simple psychotherapy.

Already, "carefully structured environments with behavior modifications are showing us in a few cases, and we don't know why, people can relearn to drink."

A major complicating factor is that alcoholism "is now in the province of the medical profession whether the medical profession wants it or not.

"I am not sure, however, the medical profession is the profession that should be taking care of alcoholism, "Dr Luce adds.

The usual medical view can narrow the sights on what alcoholism really is. "The causes are cultural, social, economic: a huge multi-disciplinary bag," he continues.

"The underlying idea behind any good therapeutic group. . .is to get the person to realize it is his fault and there is no one he can blame for his problem.

"In many cases, the label 'alcoholism' can be incidental. How can you tell a person his problem is 'alcoholism' when he can't pay the rent? If he could pay the rent, he could stop drinking."

Many people with problem drinking do well in groups and need an organization like AA. Others cannot, or would not, fit into that mould.

It is a psychological problem, not alcohol, that generally leads to spree drinking. It is important to find out the meaning behind the drinking.

Dr Luce agrees the ideas in the book are controversial and "run counter to the accepted dogma, if it is dogma, and I think it sometimes borders on dogma, in the field of alcoholism."

What can happen when dogma is challenged is aptly illustrated by the Rand Report, which should be considered seriously.

No doubt some people should not drink again. "But if there are people who can be helped and reeducated into being social drinkers, even though it is heresy in terms of the disease model, it tells us something about alcoholism.

"I am afraid that in this area, and lots of others, we don't know much and substitute dogma for facts. Very little is known about alcoholism despite the millions of dollars spent on it."

Dr Luce is a social drinker but in his college days "I used to drink heavily and by anybody's definition I was a problem drinker." When he started to write, the heavy drinking stopped.

In the same way, some people can stop drinking and smoking overnight while others have extremely difficulty. "All this means to me is that people are different."

Pot possession should be minor offence

WASHINGTON — Any penalty for marijuana possession should be decided by state law but strict federal penalties should govern trafficking and other drugs, Peter Bourne told a Senate Confirmation Committee here.

Marijuana possession should be treated like a traffic offence and be subject only to a fine. Federal penalties should be removed for those found with less than one ounce obtained for personal use, he added.

Dr Bourne made his comments to the Senate Human Resources Committee hearings on confirmation of his appointment as director of the Office of Drug Abuse Policy.

He told the senators he once experimented with marijuana while with some friends in Vietnam. He has not experimented with any other drugs.

Dr Bourne said marijuana is non-addictive, not a health hazard, and safer than cigarettes. "Fifty-thousand people die each year of lung cancer.

The medical damage demonstrated at this time against marijuana use "does not warrant making it a criminal offence for simple possession."

While drugs such as cocaine and heroin are smuggled into the US, "marijuana grows all over the country and the experience has shown there is virtually no way of controlling its use or distribution."

Pot smokers rated themselves less warm

(from page 1)

or later smoked placebo marijuana. On each occasion, the smoking was followed by a 25-minute videotaped interview in which the female partner talked about a difficult time in her life, and the study subject, the male "therapist", was asked to be helpful.

At the end of the interview each subject and partner filled out a relationship inventory (RI) which measured genuineness, warmth, acceptance and empathy. Independent raters evaluated the videotapes for empathy, using the Raskin Empathy scale.

Results showed that compared to placebo scores, active marijuana significantly decreased the subjects' overall RI scores as rated by the smokers themselves, their partners, and the videotape reviewers. Active marijuana decreased the experimental subjects' positive regard score (warmth) and their self-rating scores for genuineness. Review of the videotapes revealed that experimental subject empathy decreased significantly following marijuana intoxication.

Interestingly, said Dr Janowsky, some subjects showed increased RI scores following marijuana intoxication. These individuals became more outgoing and communicative, rather than more withdrawn while intoxicated.

Future move to scarlet predicted

(from page 1)

they are already harvesting the opium poppies by harvesting the whole plant for the straw and not lancing the pods.

In India, he said, the difficulty is "you have a problem of labor intensive requirement and there are about 100,000 families who are dependent on the lancing process for their income and we don't want to make a preemptory decision that would put all those people out of work and create undue economic hardship.

"But, in terms of long-range planning, we would like to see a gradual move towards the elimination of all *Papaver somniferum* in the world and cultivation of *Papaver bracteatum* as a main source for medicinal opiates.

"We're working very closely with the United Nations: it is a complicated issue which is not a decision for the United States to make alone. It's basically a United Nations decision and they need to take the lead in it with our support."

Prevention plans prevent too many things

(from page 1)

federal activities aimed at combatting drug abuse in America and abroad.

"We are very fortunate to have a president with firsthand knowledge and understanding of the drug abuse problem. We should be pleased to have a president with a deep concern about the issue and a personal resolve to do something about it."

Peter Bourne

In a press conference, Dr Bourne said: "One of the dilemmas always with prevention programs is that the kind of programs which prevent drug abuse prevent an awful lot of other things as well.

"There has not been the same emphasis in those areas that there has been in the area of drug abuse and drug abuse was expected to pick up the tab for all of these social programs.

"That has created two problems. One is that you therefore never had enough money to do the job right, and second, it created a feeling that it (drug abuse prevention) didn't really work, wasn't successful.

"I hope the Carter administration is going to be focused sufficiently on many of these prevention areas, not because they're related to drugs but because they're the right thing to do and that drug abuse won't be looked upon as the only source of financing for them.

"The kind of thing I'm referring to is a very intensive youth job program that is being started right now and I hope there'll be a series of other programs of this type which I see as the most effective primary prevention efforts but they don't have to be labelled drug abuse prevention."

It pays $500 to quit

OTTAWA — Sometimes it literally pays to quit smoking.

Marc Ruel, president of Les Industries du Hockey Canadien Inc, in Drummondville, Quebec, gave the last three holdouts of his office staff of 15 a no-smoking course and a $500 bonus after they had abstained for a year.

For the past three years he has also spent $150 on each office worker so, after work, he or she can go three times a week to exercise at the gym.

Mr Ruel told Input '77, a conference on occupational alcoholism and drug abuse here, that the no-smoking and fitness experiment with the office workers has "wiped out" absenteeism and increased productivity. Within a year he hopes to make a similar program available to the company's 125 plant workers.

Mr Ruel, a 41-year-old nonsmoker, said he has made the non-smoking and fitness program mandatory for all new office employees because it makes such a difference in the quality of the work.

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The Journal enters its sixth year

THIS ISSUE marks the fifth birthday in the life of **The Journal**. We're happy to be able to celebrate this occasion and we hope you're happy to share our fifth birthday with us. But just as birthdays are marked by celebrations, so too are they a time for reflection and evaluation.

In our first issue in June 1972, **The Journal** committed itself to the task of attempting "to reflect the total range of activity in the field of drug and alcohol abuse by reporting and commenting on research findings, educational approaches, and treatment programs from around the world, thus serving as a focal point for the information needed to develop positive responses to one of society's major health problems."

We recognized too that the abuse of alcohol and drugs involves not only the physician and the policeman, but all medical professionals, social workers, educators, correctional, judicial and enforcement personnel, business and industrial workers, and legislators.

Journalistically, we felt meeting these objectives would be a formidable task and an interesting challenge. It has been both.

Now, five years later, as we reflect on our original goals and the extent to which we have achieved them, we are more convinced than ever that communication in the field of alcohol and drug abuse demands an international and multi-disciplinary perspective.

Sometimes readers complain that the paper carries nothing of interest for them and sometimes writers complain that they don't know who their readers are. When the reader complains that means the writer has failed to make clear how a program or policy in another part of the world can be applied to the reader's situation. When the writer complains that means the editor has failed to convey adequately to him or her the paper's true perspective.

None of this, however, shakes our basic belief that alcohol and drug abuse cannot be dealt with in isolation. Ontario cannot deal with the problems alone any more than researchers or legislators can. We believe events and problems in Europe, Asia, or Africa, for instance, can be as significant to our readers as changes in Ontario's drinking laws. We believe too that laboratory findings have an impact on the work done in the field, and equally, work done in the field has an impact on the direction and significance of work in the laboratory or in the legislature.

Our beliefs do not make the task of publishing **The Journal** an easy one. Often hard decisions have to be made, and the hardest are those that mean a story is left out because it does not have a wide enough application or appeal. Nonetheless, the challenge, as we expected, is an interesting one. Over the past five years, as issues and advances have developed throughout the world, our coverage has attempted to keep pace.

Stories on the World Health Organization, drug programs in Thailand, increasing substance abuse in Europe, marijuana and heroin legislation in the United States, have taken their place alongside articles on prohibition in the Northwest Territories, industrial alcoholism programs in Ontario, research advances at the Addiction Research Foundation and elsewhere, and alcohol and drug treatment services in the Maritimes.

The small in-house staff in Toronto cannot meet **The Journal**'s objectives alone. We receive invaluable assistance from our contributing editors in Toronto and Washington, and our faithful team of medical correspondents throughout Canada, the United States, Europe, and other countries around the world.

Invaluable guidance also comes from our editorial board, and in this connection we would like to welcome George Ling as our first "corresponding overseas member." Dr Ling, a Canadian, is director of the United Nations Division of Narcotic Drugs in Geneva.

As we celebrate our fifth birthday, we would be remiss if we did not thank all the others who have encouraged and supported us. Our editorial board and our correspondents deserve a special vote of thanks. So do the subjects of our stories — the researchers, the social workers, the law enforcement personnel, the politicians, the patients, and the victims of drug and alcohol problems, who have over the years been most cooperative in giving us their time and their information.

Most importantly, we would like to thank you, our readers, whose encouragement, support, and helpful criticism through letters or informal conversations have made our task an enjoyable one, and convinced us that the work we are doing is worthwhile. We thank you all, and look forward to your continued support in the years ahead.

Inside Science

Social scien

By Gus Oki

AS THE human service industry continues to expand the social sciences become increasingly significant.

On the assumption that the general goal of human service is to advance the level of the 'greatest good for the greatest number' at the least expense or hazard, we can postulate a three-fold role for the social scientist. The first is to collaborate with the industry in articulating goals and objectives. The second is to assist in developing the methods and techniques for attaining these objectives. The third role is to keep the public informed. By "public" I mean those who receive the services — the practitioners, other social scientists, policy makers, funders and the general public. The social scientist has both a right and a duty to perform these roles.

Two basic and common features of the human service activities are the aim of helping and the good intentions of the helping professions. The social scientist, presuming he has established or accepted the validity of the "good intentions", might first direct his curiosity and even scepticism towards determining whether the particular human service activity has more than good intentions to justify its existence.

If our role is essentially that of handmaiden to the industry, then our social responsibility involves both the validity and efficacy of the 'industry's' activities.

More specifically, it is increasingly evident to some observers from both a psychological and sociological perspective that the continuing emphasis on attempting to effect change in people without due regard for the overwhelming importance of the individual's environment, including his institutional networks, is a gross distortion.

This preoccupation with people as targets of change is consistent with the industry's virtual, if not complete commitment to treatment. Thus, it is really not health care with its emphasis on prevention but illness treatment that tends to be the prevailing perspective.

The practitioner properly cannot be assigned the same social responsibility with respect to his role in these arrangements since commitment and belief (hopefully not blind, though) are a necessary part of his role. Therefore, it is even more essential for the social scientist to perform his third or "watchdog" role of the industry at this basic and general level.

In the more concrete and specific area of what, in fact, the industry tries to do to people and the methods employed, the same general partnership appears to prevail.

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Backgrounder

Alcoholics' kids constantly fear abandonment

by Harvey McConnell

NEW YORK — An alcohol education program for young children of alcoholics has proved extremely successful in helping them cope with problems at home.

But it has created a major problem for parents in coping with the changes in the children. This has now been alleviated to some extent by meetings of the parents, sometimes with the children.

The programs are being carried out in the Jamaica Plains area of Boston, a predominantly white, Irish-American section, where it is estimated one-third of all families are seriously affected by alcoholism.

It is a joint effort of three local agencies in the area which are linked administratively with several major Boston hospitals and clinics: the Washingtonian Center for Addictions, Peter Bent Brigham Hospital, and the Massachusetts Mental Health Center.

A joint report on the work, presented to the American Orthopsychiatric Association conference here, said the original object was to educate children about alcoholism and its effects on individual and family functioning.

The children were to be encouraged to be more comfortable expressing thoughts and emotions about alcoholism and to recognize they were not isolated in their experience with an alcoholic parent.

The original intention was a 12-week pilot program with a man and woman counsellor in charge of each one-hour session.

Two groups were established: for children aged six to eight, and the second for those aged nine to 12. Because the leaders felt the parents must be aware and open about alcoholism, a requirement was the involvement of the parents in an alcoholism counselling group.

A screening interview was held with the child and at least one parent. Parents were made aware the children might change their attitudes and behavior because of the program.

Several families decided they were not yet ready to deal openly with alcoholism, but most said the interview helped them reflect on alcoholism as a family problem.

Each group session was structured around one activity. These included drawing of family portraits, films and talks about alcoholism, games, plays, and a visit to a local detoxication centre.

The report said: "Despite the leaders' anticipation that the families' difficulties in talking frankly about alcoholism would inhibit the children's discussion, the children were delighted to have someone to listen to them.

"In fact, they spoke with considerable openness and perceptiveness about alcoholism in their own families. They listed the signs of drunkenness, drew pictures of alcoholics, and wrote plays about alcoholic families."

Although the children were concerned about the drinking of the alcoholic, what worried them most were the disharmony and rejection coming from both parents. "The children expressed constant fears of abandonment."

Even when the family was together, the children felt neglected when the alcoholic withdrew into a sulk or stupor and the non-alcoholic spouse became oblivious to the children's needs. Physical unity was tenuous — the alcoholic member absent for days and the non-alcoholic mate at work.

Because the alcoholic was frequently put out of the house for "bad behavior" the children feared their own eviction, the report continued.

"Many of the children's drawings of the family symbolically included a pet whom mother had gotten rid of because he was uncomfortable or dirty."

The children expressed considerable anxiety about the constant tension and violence at home. Many of them literally threw themselves between battling parents.

The report said the children were counselled to avoid confrontation with the drinking parent, to resist interfering in arguments, and whenever possible, to escape to their room or the house of a friend or relative during quarrels.

It was found the position of responsibility of the children within the family was striking. They cared for the alcoholic and tried to placate and protect the non-alcoholic by acting as assistant parents.

As the children became more involved in the family situation they paid less attention to social and school life.

The report said the group leaders approved the concern for both parents "but they let the children know that professionals were always available to help the parents.

"They reminded the children that protecting the alcoholic from experiencing the consequences of drinking actually keeps the alcoholic from getting needed help, and urged the children instead to assert their own needs for nurture and security at home, and to take responsibility outside the home for the tasks appropriate to their age: making friends and doing well in school."

Two evaluations of the program were held during the period, after six and 12 weeks.

Parents of the older children said the children were more comfortable with family life and were doing better in school. Parents of the younger children said the children were more outgoing, more positive, and more self confident.

In the 12-week evaluation, the parents said the gains had maintained. However, some complained half jokingly that the children sometimes upset them with their outspokenness about alcoholism and occasional refusal to help parents as they had in the past.

The report added that the children "said they felt freer to talk about alcoholism, they realized that other kids have the same problem, and they could talk about alcoholism to family and to 'trusted friends'."

The children retained what they had learned about alcoholism "and most important, they learned the ways of coping with alcohol abuse at home."

Both parents and children were unanimous in wanting the groups to continue.

Two long-term groups have been set up for the children of the first programs. This time the emphasis is less on alcohol education and more on family problems and making more use of group interaction.

After a year, it was clear the programs have been an unqualified success for the children. However, for the parents there remains a major problem.

The report pointed out: "Instead of relieving parents of the burden of the children's anxiety and anger about alcoholism at home, the groups tended to increase the parents' responsibility by encouraging the children to talk freely about the alcoholism, to avoid involving themselves in parents' problems, and to assert their own needs at home.

"Outside counselling was apparently insufficient to support parents in coping with the changes in their children."

The parents were anxious for formation of a parents group.

The report added: "In general, alcohol counsellors tend to ignore how much young children in alcoholic families see, hear, and understand about alcoholism and how deeply they are affected by it.

"At the same time, professionals who work with children — in schools, in clinics, in child guidance centres, or in welfare agencies — need to be more concerned with and more knowledgeable about the role of family alcoholism in the etiology of children's disturbances."

Unless preventive measures become a priority "there is a serious risk the children of alcoholic parents will themselves grow up to be alcoholic adults."

... Letters to the Editor ... Letters to the Editor

Smokers shouldn't suffer unconditionally

I must respond to Harvey McConnell's jeremiad on smoking (**The Journal**, March). Admittedly, smoking is a health hazard. Admittedly, some smokers can be oblivious to the sensibilities of others. Admittedly, government policy with regard to tobacco is, at best, bizarre. Let us all agree on effective health education, consideration for others, and even, rational government policy.

However, in a zealous effort to stamp out the evil weed, civility in our relations with others can be quickly forgotten. Public health cannot justify such a consequence — once again, the end does not justify the means. As human beings, smokers are like anyone else in their predilection in doing things that aren't good for them. People do eat too much, drink too much, work too much, disrupt marriages through their behavior, watch too much TV, drive erratically, and show all kinds of failings and imperfections. All of these can place unfair burdens on medical costs. While reasonable efforts to help and prevent them are necessary and valid, the state cannot become Big Mother in telling us to eat only our chicken soup.

To single out the smoker is grossly unfair. Casting the first stone at this particular form of human weakness is a rather arrogant smugness that makes one "GASP." And, stereotyping smokers as inconsiderate and intrusive is a form of prejudice worthy of contempt.

Ah, but smoking affects others. Here we must be honest. There is a difference between health or genuine discomfort on one hand, and aesthetics or ideology on the other. If smoking, in the nose of the beholder, "stinks", that is an aesthetic judgment. We do manage to coexist with cheap perfumes, leisure suits, bad music, advertising, freeways, and other affronts to that which is beauty in the world; we can even live with tobacco smoke. Of course we can hear the frenzied gasping of the afflicted. While the "second-hand" effects of tobacco smoke may cause problems in sufficient doses, the mere existence of tobacco smoke, in any concentration, in the environment is not an *a priori* hazard to others. While reasonable consideration is due to those who suffer from allergies, I do not assume an inalienable right to destroy the flowering plants and weeds in the neighbor's garden which cause me suffering during the hay fever season.

We need new conceptions of courtesy regarding smoking which recognize and balance rights. As in any reasonable codes of courtesy, consideration and tolerance are fundamental.

For the foreseeable future, human beings will continue to have weaknesses and failings, including smoking. Many otherwise good and even great people have, do, and will smoke, despite the costs and perils. In the always difficult matters of social relations and simply living with other people in a crowded society, tolerance, consideration for others, humility, and even compassion will continue to be valid. Self-righteous anger, polarization of people, intolerance, and the power politics of absolute "rights" and ideologies (even for their own good) can only make our social life more difficult and unpleasant. Surely, for example, the *compromise*, the civilized accommodation, of segrated smoking areas in airplanes is preferable to the demand for an unconditional surrender to a desire for "smoke-free skies."

Yes, I delight in smoking a pipe. I am neither inconsiderate nor apologetic about it.

Stan Sadava, PhD
Health Care Services Agency
Alameda County, Calif.
Niagara Falls, Ont.

ntists must play crucial role

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It is the social scientist's responsibility to communicate to practitioners in a manner and form that is most likely to enhance their acceptance of research results. This communication is the key to the essential synthesis between research and practice, and because of the strong vested interests of the practitioner, possibly the greater onus on establishing and maintaining effective communication lies with the scientist.

The communication role of the social scientist in the area of policy-making is in terms of how and when, he communicates his observations to policy makers.

The individual stance may be the advisory one or the advocacy one. Too, whether the activity is funded by private or public sources, the ultimate policy-making structure relative to a socially responsible human service industry must be the adequately informed political structure.

There is considerable evidence that much room for improvement exists in this area. For example, if we are to be accessories to the practising profession's expanding monopolization of the "Parens Patriae" role, we must also inform the politicians of this trend and its implications.

The most important target in terms of communication responsibility is the general public. As part of the dictum that good government depends on a sufficiently informed public, so a responsible human service industry depends on an adequately informed general public (at least in the context of our political structure). The key to satisfactory performance of this area of communication lies with the scientists' collaboration with mass media.

One way to avoid the accusation that social science is becoming an increasingly incestuous, self-serving, and socially irrelevant, if not irresponsible, activity, is to establish and maintain effective methods of telling the general public what we are up to and, in turn, what we are looking at is up to. In many instances, the accusation is correct that our preoccupation with self-enlightenment prevents the occurrence of necessary public enlightenment.

In conclusion, I would suggest that the social scientist has a crucial and unique role to play in relation to the burgeoning human service industry. In order to carry out the role, it is essential that he avoid or at least minimize his contribution to rationalizing the disparity between what is and what ought to be the human service area.

(Mr Oki is a research scientist at the ARF of Ontario).

UK wants a gambling study

By Alan Massam

LONDON — A distinguished group of British psychiatrists has urged that the social impact of gambling, like alcoholism, should be closely monitored so that "vulnerable individuals" might be protected.

In fact, the Royal College of Psychiatrists working party recommends that both a Gambling Board and an Expert Advisory Committee on Pathological Gambling should be set up to achieve this end.

The working party notes that in the majority of cases pathological or compulsive gambling is not a manifestation of mental disorder and indeed only in the symptomatic or psychopathic varieties could be identified as such. The majority of pathological gamblers, therefore, were victims of social factors.

The college report says the patterns of disturbance associated with pathological gambling "appear to be not dissimilar to those seen in relation to alcohol and drug misuse." It notes that the World Health Organization's Expert Committee on Addiction-producing Drugs drew attention in 1964 to the fact that in the case of drug misuse every drug produced its own syndrome of dependence.

"This concept of dependence has an application beyond its limited use in relation to drugs. Indeed it has been suggested that some types of pathological gambling are due to a state of psychological dependence on the activity of gambling and that this may be a learned or conditioned response arising out of various personal and social factors.

"In view of this, it is not surprising that the management of pathological gambling is fraught with difficulties once a state of dependence has been established.

"The importance of recognizing that pathological gambling as well as alcohol and drug misuse may arise out of a morbid state of dependence is that inference can be drawn from studies of the one group of disorders which have relevance to the other."

The college working party argues that the very nature of the gambling contract makes the activity a social one and that in any given population, as with alcohol, there is a scatter from those who abstain completely to those who take very large amounts.

It notes that the British Advisory Committee on Alcoholism drew attention only last year to the fact that total alcohol consumption in a population has a direct bearing on the extent of abnormal drinking in that population and that any overall increase in consumption produces an increase in the number of people with alcoholism or alcohol-related problems.

The psychiatrists claim that just as problems resulting from alcoholism and alcohol excess are in large measures socially determined "there is increasing evidence that similar factors operate in pathological gambling."

The report observes therefore, that no rigid distinction can be made between gambling in general and pathological gambling, since one merges with the other. "Furthermore, if there is an increase in the amount of gambling, this will result in an increase in pathological gambling leading to a great deal of individual and social disturbance and distress."

The working party concludes:

- That gambling should be closely monitored to measure its effects on vulnerable individuals;
- That the whole field of gambling should be a subject for legitimate academic research by sociologists and others;
- That the government should set up an expert advisory committee on gambling and the impact of proposed changes of social policy upon gambling — just as such a committee has been set up to cover alcoholism;
- That the attention of health and social service agencies should be drawn to the possibility that pathological gambling may be the underlying cause of both individual and social disturbance;
- That the dangers of excess in gambling should be a topic for health education;
- That a unit specializing in the treatment of pathological gamblers be set up;
- That further research into the causation and management of pathological gambling be established as "a matter of utmost importance."

Gambling Las Vegas style, in England.

Smoking fathers affect their unborn babies

BONN — Men who smoke more than 10 cigarettes daily are likely to endanger the life and health of their unborn children, even if the mother is a non-smoker.

This is the conclusion of an exhaustive study conducted in West Germany under sponsorship of the Deutsche Forschungsgemeinschaft, a government-funded inter-disciplinary association which coordinates almost all scientific research in the country.

According to the survey, conducted over a 12-year period by 21 hospitals and research institutes and involving 14,774 pregnant women, there is a clear pattern of heightened infant mortality and post-natal deformities when fathers are regular smokers.

A preliminary report on the study suggests prolonged ingestion of nicotine or other toxins in cigarettes does irreparable damage to male sperms. The study, however, has not brought scientific evidence to support this hypothesis.

Simultaneously the study also revealed coffee consumption by pregnant women is likely to result in underweight infants and extensive alcohol consumption to premature births. No corollary was found between deformities, weight, mortality or premature births and regular tea or cola-drink consumption during pregnancy.

Around the World

Promos are cut

The Swedish tobacco and alcoholic drink industry faces the possibility of further restrictions to their sales promotions campaigns. A special commission has recommended to the ministry of commerce that tobacco and alcohol advertising be severely restricted and "obtrusive" advertising should be banned completely. Sweden introduced a ban on the outdoor advertising of tobacco products early last year. And the alcohol content of beer sold in supermarkets is to be lowered from 3.6% to 2.8% next month. Extra-strong export beer will be supplied only by the Systembolaget liquor monopoly.

Liquor spills

A fifth of all Austrians hurt in non-traffic accidents in 1975 were under the influence of alcohol, according to an insurance survey. Twenty thousand of the 104,000 people injured either at work or during their leisure time had their judgment impaired by alcohol. An Austrian health report in 1971 showed that the country had the second largest liver cirrhosis rate in Europe. In that year, 47.2 males out of 100,000 died of the disease, compared with 49.9 per 100,000 in France in 1968.

Who's more capable?

Women who drink heavily are less likely to end up as hopeless addicts than male alcoholics, a Finnish researcher claims. Dr Pekka Kiviranta studied 200 female and 200 male alcoholics who were voluntary patients at a Helsinki treatment centre. Women were more likely than men to hold down a job, he found. "They look after themselves and their money better, and are more sociable. Drink can turn men into outcasts of society, human derelicts. It is very unusual to find a woman sinking as low as that," he said.

Between the pages

Police in Munich have arrested a heroin smuggler with about an ounce of the drug in his possession, hidden in a recent issue of *Newsweek* between two pages of an article entitled 'Heroin Invades Europe.'

Beer ads banned

Papua New Guinea's Minister for Correctional Services and Liquor Licensing, Pita Lus, has announced a ban on beer advertising. "Cabinet believes that it is a contradiction to allow advertising aimed at promoting drinking while simultaneously taking various government actions to decrease drinking as a social problem." Mr Lus said he expected wide public support for the measure which took effect the beginning of February.

Pot would be government grown, sold

Italian party is pushing for marijuana legislation

By Larry Scanlan

ROME — A small political party which a little over a year ago played a part in softening some of Italy's 'antiquated' drug laws now wants to go one step further — complete legalization of marijuana.

The *Partito Radicale*, which defines itself as a civil liberties party of the left, decided at its 17th national convention in Naples last fall to go beyond depenalization to complete legalization of marijuana.

Although agreed in principle only, without specific details, a party spokesman described this scenario: marijuana or hashish would be government grown or imported, and sold under its control in stores set aside for this purpose. Comparing the system to government control of liquor in Scandinavia (or Canada) the spokesman and a practising dentist here, told **The Journal** that although the *Partito Radicale* has existed some 15 years, it only ran for the first time in last year's national elections. The party received 400,000 votes and sent four deputies to the approximately 300-member Italian parliament. A protest party which has supported reform of Italy's divorce and abortion laws in the past, the party turned its attention in 1975 to reform of the country's drug legislation.

In that year, the party's leader was arrested for smoking cannabis at a press conference in an attempt to provoke change in Italy's drug laws.

Dr Arnao called the legislation which dated to 1954 "very backward, very, very severe, and very stupid at the same time." He complained that the 1954 legislation did not distinguish between hard and soft drugs and levied three to eight year prison terms for both.

In December, 1975, a compromise between the Social Democrats and the Communist Party in parliament ushered in new drug legislation which Dr Arnao says eliminates some of the old inequities but not entirely.

"The principles of the new law are very good in the sense that it discriminates between drug users and sellers. It also distinguishes between hard and soft drugs, the first rational approach. And the penalties are reduced, but not very much."

He says, the new law does not punish possession of any drug as long as it is for *personal* use and in "modest" quantities. This means, in theory at least, that one can possess marijuana, hashish, heroin, or any other drug in 'modest' quantities without fear of committing a criminal offence, although all such drugs found by authorities are confiscated.

But loopholes in the new law are dangerous, says Dr Arnao. The law does not precisely define "modest" quantities of a drug, leaving this open to a judge's interpretation. Dr Arnao, who has seen recent court cases applying the new law, describes "some big differences." One judge may set a modest amount at 10 grams, another at 50.

In addition, the new law can force a person caught with drugs to undergo therapy. Again the new law fails to stipulate which kinds of drug possession necessitate medical therapy. Dr Arnao claims this could theoretically allow a judge to order therapy for a marijuana user as well as a heroin addict.

Other articles in the new law which Dr Arnao labels oppressive can force a drug user to reveal where he obtained the drug, or can send a person to a three to 10 year prison term whose house is used regularly by drug takers.

The *Partito Radicale's* parliamentary deputies are trying to 'tidy up' this drug legislation and later, to legalize marijuana. Why legalize cannabis? Dr Arnao, the party's policy maker in this area, argues that more depenalization as in nine American states, leads to "increased use, increased traffic, and a growing black market without community control".

He says in Italy the same vendors of cannabis sell heroin and other hard drugs, adding the warning that expanding the soft drug market only exposes more people to more dangerous drugs.

Author of a book published a year ago translating some of the English language literature on cannabis into Italian, Dr Arnao estimates there are at least a half million cannabis users in Italy. A marijuana smoker himself, he feels that while one cannot say cannabis is safe, "we should admit it is safer than tobacco or alcohol."

But the possibility of legalized cannabis in the near future for Italy seems remote. Galloping inflation and labor and student unrest are the primary items on Italy's political plate, problems which the *Partito Radicale* must attend. The scenario of government sealed, cellophane wrapped, (and filtered?) decks of cannabis cigarettes will have to wait.

NZ makes million dollar stab at moderation

AUCKLAND — A government levy on all alcohol imported or produced here will finance a million-dollar attempt to change New Zealanders' attitudes to drink.

The money will finance the newly established Alcoholic Liquor Advisory Council, charged "to encourage and promote moderation in the use of liquor, to discourage and reduce its misuse, and to minimize the personal, social, and economic evils resulting from the misuse of liquor."

The amount of the levy has not yet been fixed, but minister of justice, D. S. Thomson, expects it will be about 5%.

This percentage would add about three cents to the price of a $6.40 bottle of whisky, and give the council about one million dollars a year out of the liquor industry's $200 million turnover.

The council's functions will include research, education, and the rehabilitation of people suffering from the misuse of liquor. It will also recommend changes to the liquor laws and liquor advertising.

The council, with its wide-ranging responsibilities, has been welcomed by agencies such as the National Society on Alcoholism and Drug Dependence.

Liquor industry support has come for two main reasons: the levy can be passed on to the consumer; and the industry sees the new scheme as putting into effect its belief education on alcohol, and treatment for its abuses, are the responsibilities of the whole community, not just the liquor industry.

At the head of the new council will be a retired soldier, Lieutenant - General Sir Leonard Thornton, former Chief of the Defence Staff.

In addition to three government members — representing the health department, the treasury, and the social welfare department — the council will have six members from the community.

Drug problems intruding on gamblers' paradise

By Lachlan MacQuarrie

MACAU — This small Portuguese colony on China's south coast is having to pay dearly for its popularity internationally with gamblers and tourists.

Increasingly, drug addicts are switching to heroin from traditional opium, more of them are injecting rather than inhaling, and drug treatment services are having to compete for resources with high priority programs for poverty relief and improved housing.

In an interview with The Journal, two Portugal-trained professionals, psychiatrist Joao Oliverira e Soresa, and social worker Fatima Perreira, describe the situation.

The tiny enclave of Macau was founded by the Portuguese in 1557, almost 300 years before nearby Hong Kong was ceded to the British following the Opium War. Its purpose was to provide a Portuguese base for the China trade, and thus Macau has for centuries been on the drug routes of South East Asia.

With a land area of only 16 square miles at the mouth of the Pearl River and with a population of about 300,000, Macau is not the manufacturing and commerical centre that its dynamic neighbor Hong Kong is. It has some small businesses and household industries, but depends mainly on the tourist trade and on revenue from gambling which is popular among Hong Kong residents but illegal in Hong Kong.

Every 30 minutes year round, hydrofoils, jetfoils, and ferries arrive and depart filled with Hong Kong residents and tourists making the 40-mile trip across the Pearl River Estuary to and from Macau's casinos, jai lai and dog racing centres.

Thus, it is impossible for Macau to isolate itself from Hong Kong's drug problems, and Dr Soresa, sent out by post-revolutionary Portugal to strengthen treatment programs, is faced with a difficult task.

Fatima Perreira

Macau's economy is not strong, and drug rehabilitation services must compete for resources and funds with other much-needed services, especially the relief of poverty and the improvement of housing. Moreover, until recently there has been little attempt to treat the *toxicomano* (drug addict). Addiction is a crime in Macau and offenders have been accommodated in an Internment Section operated on a congregate care basis by the Macau Police for "beggars, mental defectives, dependent women, the homeless, and *toxicomanos*".

"In addition", says Miss Perreira, "most of our addicts are now using heroin instead of opium and as the price continues to rise more are injecting rather than inhaling, as they once did.

"These developments are making the drug problem increasingly more serious both for the individual addict and for the community as a whole. There are no statistics to tell us how many addicts we have in Macau but we do know that the numbers apprehended in the police centre have been going up."

Dr Soresa, Miss Perreira, and Captain Luis de Oliveira of the Macau Police have a mandate to develop a program best suited to Macau's needs, and their first steps have been to develop a rehabilitation element.

Whereas in the past, incarceration was mainly on a compulsory detention basis, Dr Soresa has been attempting to encourage the admission of voluntary patients. These patients are then accommodated in a special treatment-oriented centre with those who have been assessed as having some treatment potential.

The *Centro de Recuperacao Social* (Social Rehabilitation Centre) now has a comprehensive work therapy program which includes a tailor shop, bakery, noodle factory, shoe repair shop, rattan work, automobile shop, and a farm. Dr Soresa and Miss Perreira hold individual and group therapy sessions with patients.

"However, one of the most frustrating aspects of our work", says Miss Perreira, "is that we have not yet been able to establish an aftercare program to help with integration back into the community.

"Now we must more or less leave our discharged patients on their own to work out their social and vocational rehabilitation, and we have no follow-up program to see how well they succeed. An aftercare service is our next number one priority".

A Macau street scene shows the housing problem and the areas in which the community has a drug problem. The small Portuguese colony is paying dearly for its popularity with gamblers.

A view of the Macau Social Rehabilitation Centre where the voluntary patients are housed, and where most rehabilitation is carried out.

NB is doing well contrary to its critics

By John Carroll

MONCTON — Facilities for the treatment of alcoholism in New Brunswick are probably achieving a success rate similar to those outside the province, according to the "experienced hunch" of Arthur Young, executive director of the province's alcoholism program.

Addressing "Update 77", Mr Young told the 150 delegates attending the one-day professional seminar here that in the past year and a half he has had people point out in glowing terms the merits of treatment programs in other American and Canadian localities "with the plea these programs be emulated in New Brunswick."

He said the Donwood Institute in Toronto and the Smith Clinic in Thunder Bay, Charity Hall, the Hazelden Centre, or Birchill Farm all have their supporters.

"There is no doubt the facilities I have named produce good results for some individuals" but overall success rates are overlooked "when such facilities are touted as the panacea for the treatment of alcoholism."

Mr Young said if success rates were thoroughly examined, it would be found that each of the various institutions have their own method of measuring success.

"I am convinced that if all of these programs used the same measure, then the rates of success would be very similar and close to the success rates being realized by the facilities in New Brunswick."

Mr Young was critical of a tendency to consider that the grass on the other side of the fence is greener, and that "bigger is better."

"Assumptions are made that nothing exists in the province of New Brunswick. Yet, the government of New Brunswick has expended increasing amounts over the past few years in its efforts to come to terms with the ever-increasing problems that face us."

He said it is unfortunate the field of alcoholism suffers from the same attitude as other segments of the health care field that large, monolithic structures are essential to treat alcoholics.

Placing stress on size reinforces the attitude "that the only type of care he (the alcoholic) can receive which will be effective is in-patient treatment. As long as there are no such facilities in New Brunswick, we can deplore what is in existence even in the face of evidence that bigger is not necessarily better."

The executive director argued that the strategy of improving the quality of life is an "in" notion which "should not be viewed as the panacea on which to structure prevention programs. If we consider the level of consumption in our present day society, we must acknowledge that only a small percentage of those people who consume beverage alcohol experience difficulty."

Mr Young said an approach more likely to accomplish the aim would be to encourage the continued development of positive attitudes and behavior conducive to the elimination of hazardous consumption of alcohol. He said a study conducted by his branch in Fredericton in mid-1976 revealed that the majority of people frowned on drunkenness, were not using alcohol as a means of coping with life, and had positive attitudes about the need of prevention in its broadest sense.

"It is beliefs of this kind that will have a greater effect on reducing alcohol-related problems than attempting to implement a nebulous quality of life campaign . . . we should accentuate already existing positive attitudes and behavior."

Delegates were warned that if professionals focus their energy on the alcoholic, "we are doomed to failure . . . by continuing to stress this particular aspect of the problem, we are neglecting other preventive aspects."

Mr Young referred to the large number of people who consume beverage alcohol in quantities sufficient to damage their health, but who would not be categorized as alcoholics. Accordingly, instead of the narrow focus of concentration on the alcoholic, the thrust must be toward alcohol-related problems.

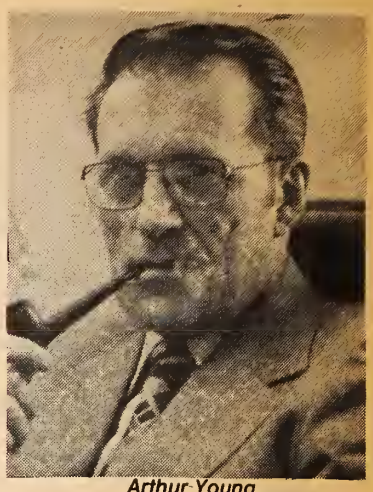
He said in treatment of alcoholism there is too little willingness to accept new and innovative approaches. There is a need for awareness that a rigid adherence to a pet theory or one methodology of treatment can "blind us to other possible alternatives."

Physicians stress medication, Alcoholics Anonymous opts for total abstinence, various religious groups stress spiritual conversion, some social workers advocate total family involvement, and others favor individual counselling.

Mr Young said the best research shows low success when abstinence is the only measure of improvement, prescribed medication is largely ineffective, in-patient treatment is no more effective than out-patient care, and professionals are no more effective than parap-professionals.

Mr Young said New Brunswick, with the lowest per capita consumption of absolute alcohol in Canada, is in "a defensive position where vigilance may ensure the rate . . . does not continue to increase."

Education ought to be an all-inclusive approach, rather than viewed as prevention per se. It should be "a strategy which is applicable to all sectors of society from the individual through to our government," he stressed.

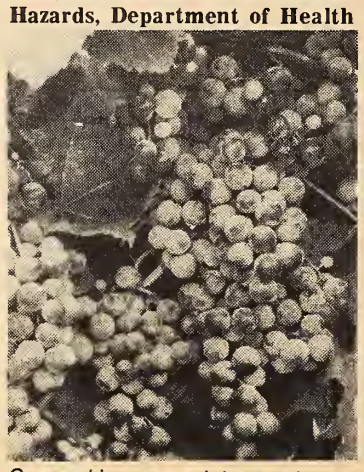


Arthur Young

Chemical in grapes attacks stomach germs

OTTAWA — Wine and grape juice reduce the activity of several viruses found in the stomach.

The chemical found in the skins of grapes appears to be responsible for the healthy side-effects of wine, say researchers from the Bureau of Microbial Hazards, Department of Health and Welfare, Ottawa.



Grape skins, grape juice, and wine reduce activity of some stomach viruses.

In a test tube experiment originally intended to determine the effects of grapes and wines on animal viruses, Jack Konowalchuk and Joan L. Spiers found grape products can kill off the polio virus and the herpes simplex virus.

They grew these viruses in cultures and then placed them in bottles containing grape extracts, raisin infusions, grape juice, and wine. The cultures were shaken to allow absorption of the viruses and then were incubated.

The polio virus was reduced a thousand times by incubating it in grape juice for 24 hours.

Grape skins and grape juice are the most potent viral killers, said the researchers in a recent issue of *Applied and Environmental Microbiology*, since they contain more of the beneficial chemicals than does wine. But red wine kills the viruses better than white. It carries nearly 10 times more of the chemicals.

Alcoholism money would address other issues

(from page 16)
to Newfoundland. What makes an alcoholic here, or what makes an alcoholic in Ontario — there's not too much difference. You've got a young man in Ontario, and we've got a young man in Newfoundland, and they're 14, and they want to be 24."

The press continues to harp on the government to spend its revenue on liquor sales for the treatment of alcoholics. An editorial in the St John's *Evening Telegram* said, in part:

"Although liquor sales constitute perhaps the government's best source of revenue, they have shown little appreciation of the responsibility which goes with the availability of this commodity."

Mr. Smith: "Last year, this is a statistic we use for our own advantage, the government received in excess of $30 million in liquor sales and gives back to society a little more than $100,000; $55,000 for our foundation, and a grant to the Harbour Light Centre."

Gil Pike, deputy minister of rehabilitation and recreation, and in charge of all alcoholism programming for Newfoundland, disagrees that liquor sale revenue necessarily coincides with the amount that should be spent on treatment:

"I don't think that's an issue. That's a tax that supports all kinds of public service like education, health, and social services, and all of the other things in the province that are directed towards people who don't need the crutches of alcohol and other drugs."

The price of liquor in Newfoundland went up a few months ago, and people continue to drink. But the mystery of marijuana and other drugs scares all but young Newfoundlanders. Aside from increasing use of tranquillizers, and other prescription drugs, illegal drugs are just not tolerated.

One Sunday afternoon in St John's, young patrons of a local club played pool or darts while they drank. A sign on the wall warned them that drinking was all they had better do:

"Anyone caught smoking anything other than legal cigarettes or any other type of drug will be prosecuted — The Management."

Mr Smith believes Newfoundland is way behind the rest of Canada in the extent of use of drugs other than alcohol:

"What happens in Toronto or Montreal with probably happen in Halifax a few years later, and will happen in St John's a few years after that.

"In Toronto, there's an indication that the marijuana situation may be levelling. This hasn't happened here yet. We're still very much on the increase. And in its wake we're starting to see cocaine, we're starting to see small evidence of heroin here, but I think it will always remain small.

"Newfoundlanders are very frightened of the whole idea of a drug. If you ask a parent what they visualize when they hear the word marijuana, you get the impression they see all sorts of very dramatic things happening. A lot of the old misconceptions are still here, about young girls turning prostitutes and becoming drug addicts. Our foundation is trying to clear up these misconceptions and put marijuana in its proper perspective."

An editorial in the Gander *Beacon-Herald*, published in a town most noted for its international airport, asked for action:

"Gander is already a pretty free-wheeling town as far as liquor establishments are concerned. A drink can be had at almost any time of the day or night. Alcoholics Anonymous is doing a thriving business, the schools have to cope with hungover youngsters, teenagers are drinking openly during the summer months only a few feet from the Court House, and businesses are complaining about the low productivity of their workers because of alcohol. But still applications (for licensing establishments) are being granted. You can starve in this town after midnight, but you need not go dry. Gander is truly the crossroads of the world, and unless we want to be known internationally as "Guzzle Gulch", if we aren't already, someone had better draw the line soon".

"Someone" is the provincial government, which has taken hard, repeated knocks from the press and some groups who are concerned about the government's apparent lack of response to statistics, and its inaction on a confidential report presented to Cabinet by the ADD: *Alcohol and Other Drug Dependencies: Provincial Program Recommendations.*

The report was not so confidential. Segments of it were revealed in 1976 to the Canadian Foundation on Alcohol and Drug Dependencies national conference. But the two presenting researchers weren't speaking on behalf of the government, according to Joan Crawford, director of special services in the department of rehabiliation and recreation. And Mrs Crawford maintains the report will only be seen by the public "when and if Cabinet desires" to release it.

Mr Pike called the report "somewhat ambitious".

"The program that was recommended was a pretty costly one, and I don't have any hesitation in saying that while the areas of activity were mapped out fairly well, and the direction will be accepted in principle, I think the achievements of the full implementation of that program are pretty far down the road."

The program recommendations were:

- Four staff positions be created and filled immediately; evaluation/research officer, community development/liaison officer, education/training officer, and a special projects officer.
- Money be set aside to hire special program consultants on a contract basis as required.
- Begin detailed research and plans needed for public education programs.
- Establish programs on a regional or municipal basis; family counselling, detoxication units, short-term treatment facilities, long-term treatment facilities, out-patient counselling, and educational programs.

The program package was broken down into five phases, with phase one requiring $303,750, and support staff to assist in program development, allowing for the development of education programs, creating family counselling services in Labrador and St Anthony, and creating out-patient counselling services in Grand Falls and Gander.

The report went on to say that while the package looked expensive, present costs of taking care of alcoholics was even more costly.

The report was shelved by government without comment, and Dr Stroh, as chairman of ADD, admitted his own personal disappointment:

"The problem here today is that we don't have any money for new programs. We're not that dissimilar from other Canadian provinces in that with the funds being cut back, with increasing costs, with higher costs of borrowing funds, this province is strapped for dollars. New programs coming along now or for the next couple of years are just out of luck."

In late April, the government brought down its new budget, and an additional $95,000 had been voted for alcoholism programming. According to Mr Pike, $50,000 has been allocated for the province's first detox unit; ADAF has received an additional $35,000 to strengthen its programs; and $10,000 will be used in Mr Pike's department, perhaps to hire an alcoholism counsellor. The Salvation Army maintained its grant of $80,000, somewhat less than half of its annual operating costs.

Wayne Smith: "People are more concerned about bread and butter issues, and of course that's kind of paradoxical, because alcoholism is a bread and butter issue.

"It's costing our government so much money in unemployment insurance, welfare payments, health costs, justice costs, and corrections costs because of booze. But they don't seem to look at that, or realize that if they do spend money in the alcoholism field it might address itself to some of these other problems."

New Books

by RON HALL

Chronic Cannabis Abuse

. . . edited by Rhea L. Dornbush, Alfred M. Freedman, and Max Fink

This volume represents the papers presented at a conference entitled Chronic Cannabis Use, held Jan 26-28, 1976, in order to review and evaluate the data from long-term users, to provide a cohesive body of knowledge about the effects of cannabis, and to attempt an extrapolation of these data to casual use and project the outcome for relatively short-term users. The conference was organized around five major areas of concern: central nervous system functioning, health implications, cannabis psychosis, the amotivational syndrome, and tolerance, dependence, and withdrawal.

(Annals of the New York Academy of Sciences, volume 282. New York Academy of Sciences, 2 East 63rd St, New York, NY, 10021. 1976 438p. $36).

Alcoholic Priests: A Sociological Study

. . . by Andrew A. Sorenson

This study of drinking among priests attempts to increase the understanding of some aspects of clergy behavior. The focus is on a group selected from Roman Catholics and Protestant Episcopal churches in the United States in order to determine what sociological and psychological factors are associated with the development of alcoholism among a sample of clergymen who are active in the ministry. Background, which is provided in terms of tracing drinking among British and American clergy, includes a discussion of the temperance movement. The research problem is discussed and methodology, including the population selection and research instrument, is revealed. Family background, vocational selection, drinking and priestly career, psychological and social correlates of drinking and a view of the alcoholic priest are presented.

(The Seabury Press, 815 2nd Avenue, New York, NY, 10017, 1977. 191p. $8.95).

Differential Treatment Of Drug and Alcohol Abusers

. . . edited by Carl S. Davis and Marlin Ruth Schmidt

This edited work is an extension of the papers presented at a conference held at the University of Iowa in 1974. Both the general theory of differential treatment models and practical applications are explored in the eight papers. The contributions include discussions of therapeutic outcomes of drug treatment, a paradigm for developing and analyzing differential treatment programs, differential treatment in a high risk urban area and with high risk school students, theoretical speculations about marijuana and drug issues, cost benefit analysis, and the differential treatment model and drug counselling.

(ETC Publications, department 1627-A, Palm Springs, California, 92262. 1977. 128p. $8.50)

The Effectiveness of Drug Abuse Treatment Volume 111: Further Studies of Drug Users, Treatment and Assessment Outcomes During Treatment in the DARP

. . . edited by S. B. Sells and D. Dwayne Simpson

The Drug Abuse Reporting Program (DARP) is a patient reporting system whose data collection included 43,943 admissions to 52 treatment agencies during a four year period. This volume describes the conceptualization and design of the program and data system and includes eight original studies on outcome measurement and the classification of clients and treatments.

(Ballinger Publishing Company, 17 Dunstar Street, Harvard Square, Cambridge, Massachusetts, 02138. 1976. 496p. $22.50).

A Better High

. . . by Harvey B. Wright

Primarily intended for teenagers, this booklets poses a series of questions in order to stimulate self-awareness, and is based on the premise that there is no need for chemical support or socially unacceptable behavior if the individual has certain basics of life. Spiritual and moral themes are interwoven with alcohol and drug use information in attempting to guide the reader in answering the questions.

(Research and Education on Alcohol and Drugs, PO Box 2437, Springfield, Illinois, 62705. 1976. 53p).

Other Books

Principles of Neurobiological Signal Analysis — Glaser, Edmund M., and Ruchkin, Daniel S. Academic Press, New York, 1976. Properties of biological signals, signal processing, evoked potentials. 471p. $24.70.

Alcohol — Proof of What? — Lee, Essie E. Julian Messner, New York, 1976. Alcohol and youth, index. 192p. $5.79.

Marijuana: A Short Course — Robbins, Paul R. Branden Press Publishers, Boston, 1976. 70p. $5.95.

The Booze Game — Skimin, Robert. Newfoundland Outdoors Publishing Company, Holyrood, 1976. 93p. $4.95.

Women Alone: The Disaffiliation of Urban Females — Bahr, Howard M., and Garrett, Gerald R. D.C. Heath And Company, Toronto, 1976. 207p. $18.

A Family Approach to Problem Drinking: The Four Week Family Forum — Howard, Don, and Howard, Nancy. Family Training Center, Columbia, 1976. 185p. $5.45.

Family Therapy: Theory and Practice — Guerin, Philip J. Jr (ed). Gardner Press, Inc, New York, 1976. Theory, clinical issues, techniques. 553p. $21.17.

51st Annual Report and Financial Statement — Saskatchewan Liquor Board — Queen's Printer, Regina, 1976. Year ended March 31, 1976. 19p.

A First Report of the Impact of California's New Marijuana Law — Budman, Kenneth B. State Office of Narcotics and Drug Abuse, State of California, Sacramento, 1977. 51p.

The Working Addict — Caplovitz, David. Graduate School and University Center of the City University of New York, NY, 1976. Social characteristics, drug histroy, work history, drugs on the job, 176p. $10.

The 1976 Evaluation of the Navy's Alcohol Rehabilitation Programs — Bucky, Steven F. Naval Alcohol Rehabilitation Center. San Diego, 1976. 18p.

The Cottage Meeting Program: An Approach to the Prevention of Alcoholism — Boswell, Bernie, and Wright, Sandy. The Cottage, Salt Lake City, 1977. History and concepts, content, training program, appendix. 18p.

Economic Issues in Alcohol Control — Lidman, Russell M. Social Research Group, School of Public Health, University of California, Berkeley, 1976, 24p. $1.

Alcohol, Drugs and Driving — Mattila, M. (ed). S. Karger, Basel, 1976. "Satellite Symposium of the 6th International Congress of Pharmacology on Alcohol, Drugs and Driving, Helsinki, July 26-27, 1975." 102p. $25.50.

Annual Report: April 1, 1975, to March 31, 1976 — Alberta Alcoholism and Drug Abuse Commission — Edmonton, 1976. 40p.

Forty-second Annual Report 1976 — Texas Alcoholic Beverage Commission Austin, 1976.

1977 Report To The Legislature: California Alcoholism Program — Office of Alcoholism, State of California, Sacramento, 1977. 72p.

Marihuana: An Annotated Bibliography — Waller, Coy W., Johnson, Jacqueline J., Buelke, Judy, and Turner, Carleton E., Macmillan Information, New York, 1976. 3,045 citations. 560p. $16.50.

Reports of the Side Effects Associated with the Use of Drugs 1968-1975 — National Drugs Advisory Board, Dublin, 1976. 124p.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

The Chemically Dependent Woman: Recognition, Referral, Rehabilitation — June 4, 1977, Toronto, Ontario. Information: Heather Rowe, The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 32I.

Annual Meeting of the Canadian Tuberculosis and Respiratory Disease Association, Canadian Thoraic Society — June 13-15, 1977, Moncton, New Brunswick. Information: Canadian Tuberculosis and Respiratory Disease Association, 345 O'Connor St, Ottawa, Ontario, K2P 1V9.

Canadian Guidance and Counselling Association 1977 National Conference — June 14-18, 1977, Montreal, Quebec. Information: The Secretariate, Congress National SCOC 1977, 1895, Avenue de La Salle, Montreal, PQ, H1V 2K4.

The Canadian Medical Association and Quebec Division Annual Meeting — June 19-24, 1977, Quebec City, PQ.

2nd National Symposium on Driver Education — June 23-25, 1977, Toronto, Ontario. Information: Canada Safety Council, Traffic Section, 1765 St Laurent Blvd, Ottawa, Ont, K1G 3V4.

Drug Information Association — 13th Annual Meeting — June 28-30, 1977, Toronto, Ontario. Information: Dr Bob Waters, Fisions, 26 Prince Andrew Place, Don Mills, Ont, M3C 2H5.

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference — FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall Street, Vanier, Ontario.

Alberta Alcoholism and Drug Abuse Commission Summer School on Alcohol and Drugs — July 24-29, Calgary, Alta. Information: Marg Bailey, AADAC, 812-16th Avenue SW, Calgary, Alta, T2R 0T2.

Institute on Addiction Studies — Aug 14-19, 1977. McMaster University, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Drive, Suite 603, Don Mills, Ont, M3C 1YB.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: conference headquarters, c/o The Portage Institute, 3418 Drummond Street, Montreal, PQ.

1977 World Congress on Mental Health — Aug 21-26, 1977, Vancouver, British Columbia. Information: Secretariat, World Federation for Mental Health, 2255 Wesbrook Mall, University of British Columbia, Vancouver, BC, V6T 1W5.

21st Annual Meeting of the American Association of Automotive Medicine — Sept 14-17, 1977, Vancouver, British Columbia. Information: Traffic Injury Research Foundation of Canada, 1765 St Laurent Blvd, Ottawa, Ont, K1G 3V4.

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

20th Annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9.

United States

Alcoholism: The Dynamics of Intervention and Recovery — June 1-2, 1977, Louisville, Kentucky. Information: Joe Trabue, department of HPER, University of Louisville, KY, 40208.

4th Regional Addiction Institute North Central Texas Region — June 2-3, 1977, Arlington, Tex. Information: Tom Armstrong, Institute coordinator, North Central Texas Council of Governments, PO Drawer COG, Arlington, Tex, 76011.

1st New York State Conference on The Other Victims of Alcoholism: June 8-9, 1977, New York, NY. Information: New York University, department of Health Education, South building, 5th floor, New York City, NY, 10003.

Alcoholism: A Clinical and Community Approach — June 13-17, 1977, Cleveland, Ohio. Information: Fay B. Fine, Continuing Education Program, School of Applied Social Sciences, Case Western Reserve University, 2035 Abington Road, Cleveland, Ohio, 44106.

American Medical Association Annual Meeting — June 18-23, 1977, San Francisco, California. Information: James H. Sammons, 535 North Dearborn Street, Chicago, Illinois, 60610.

1977 New England School of Alcohol Studies — June 19-24, 1977, Colby College, Maine. Information: Jan Swift Durand, coordinator, PO Box 11009, Newington, Connecticut, 06111.

University of Utah School on Alcoholism and Other Drug Dependencies — June 19-24, 1977, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

6th Ohio Drug Studies Institute — June 21-24, 1977, Westerville, Ohio. Information: Jim Shulman, Ohio Bureau of Drug Abuse, State Office Tower, 30 East Broad Street, Room 1352 A, Columbus, Ohio, 43215.

35th Annual Session of the Summer School of Alcohol Studies — June 26-July 5, 1977, Rutgers University, New Brunswick, New Jersey. Information: Rutgers University, New Brunswick, New Jersey, 08903.

19th Annual Workshop on Problems of Alcoholism, Alcohol Education and Drug Misuse — June 30, July 19, 1977, Bloomington, Indiana. Information: Dr Ruth C. Engs, department of Health and Safety Education, HPER, Indiana University, Bloomington, IN, 47401.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Center, McLean Hospital, 115 Mill Street, Belmont, Mass, 02178.

Issues in Alcoholism: 3rd Annual Colorado Summer School of Alcohol Studies — July 10-15, 1977, Denver, Colorado. Information: Alcoholism Council of Colorado, 2727 Bryant Street, Suite 310, Denver, Col, 80211.

7th Annual Kentucky School of Alcohol Studies — July 17-22, 1977, Morehead, Kentucky. Information: Kentucky School of Alcohol Studies, department for Human Resources, Bureau for Health Services, Room 266, 275 East Main Street, Frankfort, KY, 40601.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking" — July 27-29, 1977. Seattle, Washington. Information: Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, Seattle, Wash, 98195.

Summer Institute of Drug Dependence — Current Issues, Research, New Directions in Alcohol and Other Drug Problems — Aug 15-19, Colorado Springs, Colorado. Information: Institute Coordinator, PO Box 1791, Colorado Springs, Col, 80901.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977, Honolulu, Hawaii. Information: Rosa Torres, congress coordinator, 6th World Congress of Psychiatry, 1700 18th Street NW, Washington, DC, 20009.

1st International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation Inc, 222 East Redwood Street, Baltimore, Md, 21202.

Alcohol and Drug Problems Association of North America Annaul Meeting — Sept 25-30, 1977, Detroit, Michigan. Information: ADPA '77, 755 Big Beaver Road, Suite 2018, Troy, Mich, 48099.

National Alcohol and Drug Treatment Outcome Evaluation Conference — Sept 26-27, 1977, Nashville, Tennessee. Information: Linda C. Sobell, director, Alcohol Programs, Dede Wallace Center, PO Box 40487, Nashville, Tenn, 37204.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 26-30, 1977, New York, NY. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, AZ, 85010.

Abroad

International Seminar "The Future of Sobriety" — June 2-3, 1977, Vaasa, Finland. Information: M. Voipio, executive secretary, Suomen Raittiusjarjestojen Liitto, Annankatu 29 A 12, Helsinki 10, Finland.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977. Dresden, German Democratic Republic. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

4th Institute on Drugs, Crime and Justice in England — July 3-24, 1977, University of London. Information: Arnold S. Trebach, director, Institute on Drugs, Crime and Justice in England, Center for the Administration of Justice, The American University, Washington, DC, 20016.

Dilemmas in Treatment — July 24-29, 1977, Venice, Italy. Information: Clara Shapiro, conference coordinator, Center for Policy Research, 475 Riverside Dr, New York, NY, 10027.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977. Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28-Sept 1, 1977, Bergen, Norway. Information: Peter Nathan, department of psychology, Rutgers University, New Brunswick, New Jersey.

Newfoundland has fewest treatment services in Canada

Under the surface of the world next door

By Karin Pargas

ST JOHN'S, NFLD — Tom slurred his words as he spoke to the host of a popular "hot-line" radio show. Tom had heard commentator Bas Jamieson talking a few minutes earlier about an upcoming mini-convention of Alcoholics Anonymous in St John's, and he was confused.

What, he asked Bas, did the word alcoholism mean?

"Dere's no such ting as an alcoholic, none in de world," Tom informed Bas in a dialect reminiscent of the Irish ancestry that most Newfoundlanders share.

Another male caller spoke almost inaudibly about alcoholism:

"I think it's the greatest sickness of all. You wake in the morning with a hangover, and you're shivering, and you're shaking. You can't go to work. You've got to get another drink."

Bas suggested AA to him, as the organization is the most visible service available to alcoholics on the island. But for the third caller, another male, AA was not the answer:

"I started drinking when I was 14-years-old, and now I'm nearly 71. You talk about going to AA meetings and stuff like that. You know who I went to? I went to the Lord. I didn't know the days of the week, and I went to the doctor and he ordered me to give it up. I had an enlarged heart, damaged liver, and high blood pressure. And I've been giving it up now for a year and three months. I'm a better man now for my community, better man for my church, and a better man for my lodge."

THE BACK PAGE

The few who called CJON radio that morning a few days before Easter — between calls to Bas from welfare recipients who weren't receiving, and women seeking work as cleaners — could be among those who are counted in statistics that say there are more than 12,000 alcoholics in this province of 558,000 people. Other statistics say anywhere from 5% to 25% of the people on the island and the territory of Labrador on the eastern end of Canada, have a problem with liquor.

Whatever the correct percentage, increased drinking is worrying those few who are tackling the problem of convincing the many "ranting and roaring Newfoundlanders", as the song goes, that how much and how often one drinks is not a sign of masculinity.

Women are almost excluded: they have only just begun to make appearances in large numbers at AA meetings. The number of female problem drinkers has risen as women drinking in public become more and more tolerated, in a province 10 years behind the rest of Canada in everything except the cost of living.

Newfoundland's been a part of Canada only since 1949, and some old-timers are reluctant still to consider themselves a part of the country. The province's link with Canada is marred geographically by the short stretch of the Atlantic Ocean separating the island from the mainland. And its historically poor economy and standard of living further alienates the people. The threads of Confederation become even more tenuous as Quebec separatists plan their own emerging nation: the four Maritime provinces, of which Newfoundland is one, have already been dubbed, in preparation, the "Atlantic orphans."

Local newspaper advertisement

Newfoundland's department of tourism is taking advantage of mainland Canada's image of the province, attempting to lure people and their vacation money to "another world next door."

The image: a rugged, rocky island, surrounded on its perimeter with quaint fishing villages; the houses built of pastel clapboard; the friendly people with their delightful "accents"; the wilderness that makes up most of the interior; the caribou and the moose; and of course, Screech, Newfoundland's own special dark rum. Newfoundland's bumpy highway can take tourists to places like Tickle Bay, Heart's Delight, Joe Batts Arm, Happy Adventure, Blow-Me-Down, and Come-By-Chance.

Scratch beneath the surface and the charm wears thin.

While other Canadians swoon in the face of an all-time high unemployment rate of 7%, the statistic is more of a joke to Newfoundlanders where 23% of the people are without jobs, and a winter without work, when the ports freeze over, is the norm. For those who do find work, the average annual wage is less than $5,000 a year.

In 1966, Newfoundland recorded the lowest per capita consumption of alcohol in Canada. By 1973, it had experienced an 87.8% increase in per capita consumption, the greatest increase in that time period in the country. It also achieved the dubious distinction of recording the highest per capita consumption of beer in Canada outside the Yukon and the Northwest Territories, and the 6th lowest per capita consumption of alcohol in the entire country. (**The Journal**, Aug 1976).

More statistics:

• Based on data collected from provincial hospital records between 1970 and 1973, there was a 129% increase in frequency of primary diagnosis of cirrhosis of the liver, a 102% increase in the frequency of diagnosis of behavioral problems related to alcohol, a 237% increase in alcohol-related psychiatric problems, a 150% increase in alcohol poisoning requiring hospitalization, and a 297% increase in reported hospital costs for alcohol-related disorders (primary diagnosis only).

• The costs of drinking and driving between 1970 and 1975 also soared: a 238% increase in the number of impaired drivers charged, a 100% increase in fatal car accidents involving alcohol, and an 85% increase in the rate of alcohol-involved accidents resulting in property damage of more than $200.

The paradox emerges. The prevention and treatment of alcoholism remains a low government priority because times are hard all around, and the government's attempts to balance a budget make it difficult to make new inroads in social services.

The province has the fewest services available in Canada for the treatment of alcoholics and drug dependents.

AA operates about 35 groups in the province, 18 of them in the capital city of St John's.

The Salvation Army Harbour Light Centre runs a 90-day treatment program for male alcoholics in St John's. It's the only treatment plan explicitly for alcoholics and they come from across the province and Labrador.

The Alcohol and Drug Addiction Foundation of Newfoundland (ADAF), a private agency, is run essentially by six workers in three offices; one above a drug store in St John's, another in Corner Brook on the west coast of the island, and a "dormant" office in Grand Falls, maintained for the moment, by a part-time secretary.

The Alcohol and Drug Directorate (ADD), an inter-departmental committee of the provincial government, has not met since it presented a report to Cabinet outlining the need for programs. That report was presented in December, 1975.

Wayne Smith, director of ADAF, admits the agency is doing the best it can to embarrass the government into spending more money:

Harbour Light, St John's

"We're the only province in Canada that doesn't have an official agency of government. We're a voluntary, non-profit organization, that coincidentally receives a small operating grant from government. But we can't respond adequately to the needs of the province because we're not an official government body. We don't care where it (the money) goes. We don't care if it goes to our foundation, or to a hospital, or to another treatment centre.

Pockets of the island stand out as examples where alcohol has left a visible smear.

Mr Smith: "Stephenville has a stormy history. First, there was a very big American Armed Forces base there in the late 1940s which changed the whole community milieu. Then the Army left about 10 years ago creating a tremendous vacuum — the lifestyle of being a base community — cheap liquor, cheap cigarettes, and parties, disappeared. So the people of Stephenville have been through such a shock experience, it would create an experience that breeds alcoholism.

"A lot of mining towns in Newfoundland have high alcoholism. St Lawrence is a mining town, and the writing on the wall says that in another couple of years (the mines) will close. That town is a very depressing place because a lot of men have died at a very early age. If you go into the local graveyard, you see graves of men who died at 35 because of silicosis and lung cancer . . . So what do the people have to do but drink all day and all night; people who are working, knowing their days are numbered in regards to employment, and perhaps their life."

Labrador, Mr Smith continued, has "an incredible problem" with the native Indian population.

"Our penitentiary in St John's usually houses about 25 or 30 Indian or Eskimo people from Labrador at any one time, and 100% of the reason why they're in there is booze. They're in there because of alcohol-related offences. It could be assault with intent to kill, or it could be as simple as being drunk in a public place."

Bell Island, an iron-ore mining community before the mines closed down about eight years ago, is a short trip by car and ferry from St John's. The 8,000 people on Bell Island are served by two beer distributors, two liquor lounges, and a snack bar. Food and clothing must be purchased off the island.

For young people, the pressure is on. The drinking age was lowered from 21 to 19 years in 1972, and Mr Smith is seeing the effects through ADAF:

"Fifteen months ago, if you were to ask me what I knew about teenage alcohol abuse, I would honestly say I didn't know very much. This year, not a month goes by that we don't see someone who's 21, 19, or 22, who is showing every sign and symptom of full-blown alcoholism. It didn't happen five years ago. Guidance counsellors are seeing in the high schools problems that are almost irreversible — drug abuse, alcoholism, and Monday morning hangovers."

Young people who want to hear a rock group perform in St John's must break the law in order to do so, for the groups rarely perform in unlicensed halls. Once they're in, kids are faced with the choice of buying a bottle of beer for 80¢ or a cola for $1.50.

In Lewisporte, a town on the northern coast of the province, with a population of 4,500, there are no movie theatres, but three bars. In one, the Blue Fin Inn, young people may pay two dollars to watch a movie brought in by the innkeeper while they drink.

One of the most flourishing industries on the island — the alcohol advertising industry — gets part of the blame for increasing alcohol use.

For Newfoundlanders, males at any rate, the liquor advertising industry promotes the image of an islander as a hearty, hard-drinking, good-timer. The brewers who bottle brands of beer unique to the province, keep jingles flowing on radio and television, and sponsor sporting events. In St John's, bottlers of Blue Star beer sponsor a dart league — and the dart leagues compete usually in a local tavern or club.

Says one Blue Star radio commercial:

"Let's all get together on this seafaring land. Blue, blue, Blue Star, the beer that's in demand. You can take a toast to Newfoundland with a Blue Star in your hand."

Mr Smith feels there is no way to counteract this effective advertising:

"You take the ARF in Ontario, which puts out some good audio-visual material, but no one, but no one, can compete with the colorful fancy, top-notch advertisements that the breweries put on. They're spending millions. There's no budget for that kind of thing because they're trying to capture their part of the market, plus increase consumption."

Carl Stroh, a psychologist in the Mental Health Division of the provincial department of Health, and Chairman of ADD agrees:

"The idea of counter-advertising is a waste of time and energy, and the solution isn't to have the money to counter the industry. The solution is to ban totally the promotion of alcoholic beverages." But that won't happen in Newfoundland, or any other Canadian province for a long time, he added.

Captain Donald Snook, administrator of the Harbour Light Centre explained the dilemma facing Newfoundlanders:

"They tell us on TV to drink. Alcohol is socially accepted, and not only that, but the media and false advertising — which obviously it is — to me seems geared to young people. And it's showing them a lifestyle that is part of becoming a man or a woman.

"I don't think heavy drinking is peculiar

(See — **Alcoholism — page 13**)

ADAF main headquarters, above drug store, St John's

The Journal

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Feds will watch MDs, pharmacists

By Bryne Carruthers

OTTAWA — The federal health department is cracking down against medical practitioners and pharmacists who either intentionally or unintentionally allow narcotics and other controlled prescription drug products under their control to be misused.

New federal narcotic control regulations give the federal health minister the power to cut off any or all of five categories of controlled drugs — including, most importantly, narcotics and oral prescription narcotics — if a pharmacist or medical practitioner cannot provide a full accounting to the government, when asked, on the disposition of all controlled drugs provided him by licensed dealers.

The power to cut off the supply of controlled drugs for a period of a year or more is exercised by notifying licensed dealers that it is forbidden to supply specified controlled drugs to named pharmacists or medical practitioners. The restricted list is issued every month.

In effect, the pharmacists, doctors, or dentists won't be able to get the drugs again, until the government and the professional licensing association involved are convinced the problem has been eliminated.

For a doctor, the "problems" which could lead to such a cut-off of supply include:

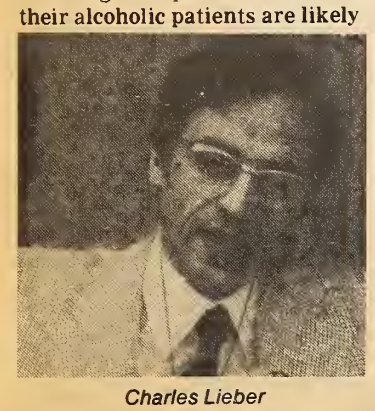
- violating a rule of conduct of the provincial licensing authority that leads the provincial medical licensing authority to request the federal health minister to suspend some or all of the practitioner's prescribing privileges;
- repeatedly administering a narcotic, or an oral prescription narcotic to himself on his own prescription or order "other than in accordance with normal or accepted medical (or dental) practice";
- repeatedly prescribing such substances to his spouse, parent, or child "for other than normal or accepted medical or dental use";
- being unable to demonstrate that all narcotics or oral prescription narcotics purchased or obtained by him have been used or dealt with by him in accordance with federal regulations, and that they therefore haven't been misused, after a request for

(See — Restrictions — page 3)

Test may predict cirrhosis

By John Shaughnessy

WASHINGTON — Alcoholism workers may soon be able to detect early stages of heavy drinking and predict which of their alcoholic patients are likely to develop liver disease and cirrhosis.



Charles Lieber

Blood tests developed at the Bronx Veterans Administration Hospital in New York show promise for the detection of early heavy drinking and liver disease. A third test, done by biopsy, may permit clinicians to predict which of their alcoholic patients will progress from liver disease to cirrhosis and which will not.

Late last year, Charles S. Lieber, chief of the Section and Laboratory of Liver Disease at the hospital, reported on the blood test to detect early heavy drinking (**The Journal**, Jan 1). Dr Lieber found that in alcohol-fed baboons, who were in no way malnourished, one amino acid — alpha amino-n-butryic acid — was increased 700% compared to controls.

The amino acid level was also increased in human alcoholics, and after studying "a couple of hundred alcoholics" Dr Lieber found 80% of verified alcoholics had a positive test compared to only one percent of controls. As a result he suggests the test may be a possible biochemical marker of alcoholism.

Reviewing this work at a press conference here, Dr Lieber said the test is superior to other approaches because it is independent of liver disease — patients who have liver disease of non-alcoholic origin do not have a positive test. In addition the test remains positive at least a week

(See — Liver — page 5)

Doctors should be aware of resources

Women need referrals not pills

By Anne MacLennan

TORONTO — The role of doctors is not to solve all of a woman s problems but to identify the social stresses creating her symptoms and recognize the existence of resources that can help, says Ruth Cooperstock.

"Most women aren't going to doctors because they've got cancer or heart disease. They're going with vague, poorly-defined symptoms. They're going because they're feeling they need help with their lives.

"And doctors should not simply hear headache or low back pain or tension and respond with a prescription. They should ask why and determine who can be of help," Ms Cooperstock told a meeting here on The Chemically Dependent Woman, sponsored by The Donwood Institute.

She said such resources would include social agencies, marital counsellors, day care centres, employment and rehabilitation services, retraining programs, therapists, and, in larger communities, women's counselling and education centres.

Ms Cooperstock, a scientist in the social studies department of the Addiction Research Foundation of Ontario, has worked on studies of prescribed psychotropic drug use for 11 years. Her major interests are consumption patterns of high risk groups, such as women; physicians' prescribing habits; and the social meaning and consequences of use of psychotropic drugs.

Referring to the documented higher use of prescribed tranquillizers by women than men, and more frequent visits to doctors by women, she said three major reasons have been suggested for sex differences in illness experience.

They are that:

1) women report more illness than men because it is culturally more acceptable for them to report ill;
2) the sick role is relatively compatible with women's role responsibilities and incompatible with those of men;
3) women's assigned social roles are more stressful than those of men and, therefore, they have more illness.

Of the three, she said, only the third reflects actual illness: the first two reflect rather "illness behavior" or the acceptance of the "sick role."

"There is, in fact, a very real difference between reporting a day in bed and actually being physically ill," she said.

"Sickness behavior which results in visits to the doctor has the potential to result in more prescriptions. So what we want to know are what are the differences in illness behavior among women occupying different social roles. And how do these differences relate to what we now know about consumption of psychotropic drugs?

"Do certain roles predispose a women to needing help? What kind of help? Accepting an unsatisfactory role?

"Before anyone is dismissed by a doctor as needing a tranquillizer to settle her nerves, a careful examination of the lifestyle and roles filled or unfilled, may help her find other solutions to the problems that created the call for help," said Ms Cooperstock.

Murderers in drug study

By Harvey McConnell

SAN QUENTIN, CA — A unique group of amphetamine abusers — death row inmates who committed multiple murders while taking the drug — are being studied by psychiatrist Stephen Asnis.

All of them were on extremely high doses of amphetamine, from 1,000 mg to 3,000 mg a day, and near the end of a run when they killed.

Dr Asnis is a staff psychiatrist at San Quentin prison, runs an impatient psychiatric service for prisoners at San Francisco General Hospital, and serves at the Haight-Ashbury Free Medical Clinic.

Soon after starting a year ago to care for the death row prisoners, he and chief psychiatrist Paul Gilbert "hit upon this fascinating observation that a lot of people involved in multiple murders were also involved in stimulant drugs and their abuse, and a certain number had taken amphetamines.

"These people had a pattern of doing things that didn't make a lot of sense, except to that particular person."

Dr Asnis has no doubt the violence that led to death stemmed from amphetamine abuse.

"Not only that, but it is amazing that two or three years after the incident, when the convict has no vested interest in withholding information, he believes it was the amphetamine that a lot of times 'messed up my mind.'

"I am sure also that there are a lot of people in the prison, and who are not on death row, who won't say they were on amphetamines or other stimulants at the time of their crimes.

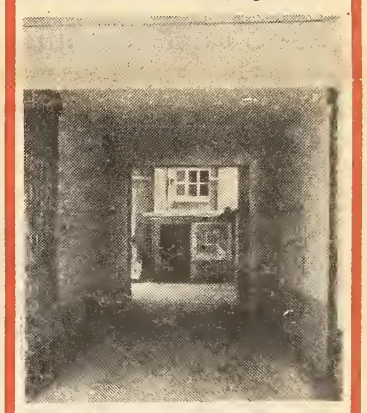
"At the same time, there are a number of other prisoners who have told me they feel if they had kept up their amphetamine abuse they would certainly have been

(See — Stimulants — page 4)

Factsheet

In this issue, **The Journal** introduces a new service to its readers. Each month a full page will be devoted to a round-up of information on a particular subject in the alcohol and drug dependence field. Compiled by researchers at the Addiction Research Foundation of Ontario, Factsheet will provide a handy, tear-out reference sheet. This month, readers will find Factsheet on page 13. The subject is alcohol. Next month, watch for a Factsheet on tranquillizers.

Bon Accord, a rehabilitation program for skid row men, operated by the Addiction Research Foundation of Ontario, will likely be transferred to some other agency within the next few months. See Inside Science, page 8.



There's a lot of heroin in West Germany these days, and records kept at the Hannover Youth and Drug Centre (above) show that addicts are younger. A new breed of addict is also emerging — the "white-collar" abuser. See The Back Page.

The US Navy is tackling its major problem of alcoholism with a country-wide prevention program that has achieved a recidivism rate of less than 7%. The program has made an important impact on the Navy's annual rate of deaths, injuries, and property damages resulting from alcohol-related incidents. See page 6.

Regular features

Understanding alcohol, drug dependency isn't enough

Health workers must also know about women's issues

TORONTO — Social and health care workers are daily encountering chemically dependent women, knowingly and unknowingly.

"The challenge is to make all of these encounters ones which count in the enormous task of reaching and helping these women," according to Lavada Pinder, director of the Ottawa Carlton program of the Addiction Research Foundation of Ontario.

It may seem a very modest approach to narrow the issue to deliverer-consumer transactions in view of the enormity of the problem, Ms Pinder told a meeting here on The Chemically Dependent Woman.

"Because of this, I want to be clear this transaction must be seen within the social context in which it takes place. It must be recognized these transactions take place within systems and structures which are frequently designed to maintain existing attitudes and practices."

Overcoming the obstacles requires health and social care workers to get in touch not only with issues of drug and alcohol dependency but also women's issues.

They must begin to wrestle with their attitudes towards women's role, status, and aspirations, recognizing their meaning on both an emotional and practical level. If they are women, they must deal with their feelings about themselves as women, she said.

"They must take time to become informed about chemical dependency and the intervention strategies their particular discipline can bring into play."

Ms Pinder suggested three opportunities can be singled out which fall within the responsibilities of most social and health care workers — education, assessment, and crisis intervention.

They are all functions which "can take on meaning in the prevention and intervention aspects of working with women with chemical dependency.

"Education is vital. There is the education of self and the education of consumers of service. They go hand in hand."

She said education of consumers may range from the low key approach of distributing pamphlets and displaying posters to orientation of all consumers to the facts related to drugs and alcohol, and organizing study groups. It is the steady, long-term inclusion of education materials and instruction which has impact and contributes to demystifying the subject.

"If assessment is considered ongoing, then it can mean that not only will queries related to drug and alcohol involvement and their linkage to presenting social and psychological problems figure prominently at intake, but also that deliverers of service will continuously be mindful that women may be finding chemical solutions to social problems.

"Once again, it is the constant attention to these issues which pays off."

Crisis is considered by many in the addictions field to present excellent potential for intervention, said Ms Pinder. And women will respond to help when a crisis makes alcohol an unattractive solution. At these times, social and health care workers can be at the ready, knowledgeable about resources, aware of alternatives, sensitive to a woman's potential.

BC drunk drivers to get morgue tour?

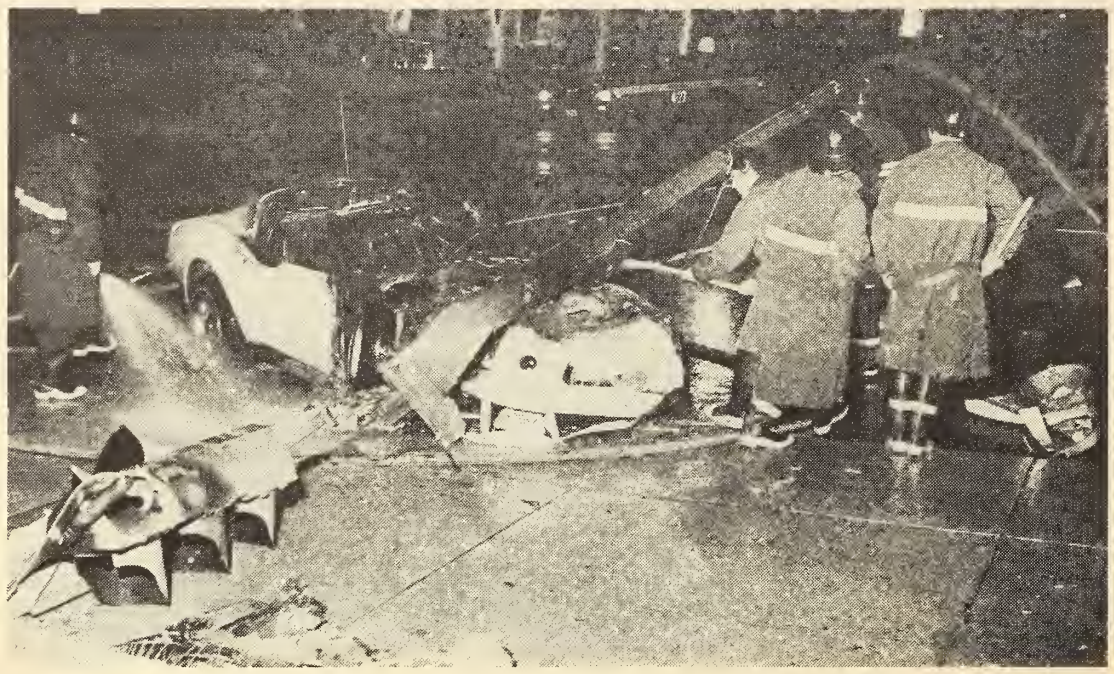
VANCOUVER — Impaired drivers in British Columbia may be forced to visit the morgue or hospital emergency wards to see for themselves the horror of traffic accidents.

The provincial government is considering this plan as part of an "all out war" against the drinking driver.

"We are putting the province on alert. We mean business," said Attorney General Garde Gardom.

The government has also announced year-round, province-wide roadblocks, and use of 14 special police vans for on-the-spot breath tests of drivers suspected of drinking.

Mr Gardom said drinking drivers cost the province more than $52.6 million a year, including $32.7 million in medical and hospital costs; $5.2 million in court costs; $3.2 million for law enforcement; and $2.5 million for correctional services.



Impaired drivers in BC may be forced to view horror of traffic accidents.

Aku-Aku gets a brewery with help from CIDA

By Wayne Howell

HAD THE tiny Polynesian island not been dumped upon by sea birds for millenia, Aku-Aku would be just another coral island in the South Pacific.

But, dumped upon it was, and now the inhabitants of the isle are reaping a rich harvest: their guano is much in demand, giant ships carry the rich fertilizer to distant ports, and Aku-Aku is coming of age.

Amid the commercial hustle and bustle, island life goes on as before: the islanders still crush breadfruit, dump it into huge earthenware pots, and set the pots in the sun. What they get in five or seven days is sao-ho, an unpredictable milky beverage; unpredictable because of the bugs in it — the real bugs, both living and dead; and the technical bugs — the kick tends to vary from "nil" to "wow". The whole sao-ho business was very embarrassing to the king of Aku-Aku.

"This is all so ....primitive," sighed the king, pointing out the sao-ho pots as he was showing a new CIDA technical expert around the island in the royal Mercedes Benz.

"Why not build yourself a brewery?" asked the CIDA expert. "You might as well organize it so you can get your share of the take."

"How do you mean?"

"Taxes," said the CIDA man.

The king's eyes widened. It had never occurred to him that the royal treasury could be supplemented in this manner; he thought taxes were just the 0.05% of the guano profits that the nice men from Multinational Corporation gave him.

"But, surely such a wonderful thing as a brewery can only be had in rich developed countries," said the king wistfully.

"Oh no. Jean Talon established a brewery in 1666 when there were just 3,215 souls living in rude habitations in the Canadian wilderness; it is never too soon to get into breweries," said the CIDA expert.

"Then let's go," said the king, clapping his hands with glee.

"Fine, now the first thing you must establish is what your bloat-limit will be. You must understand that it will be your serious sao-ho drinkers that will drink most of your new-improved-standardized-sterilized-pasturized sao-ho. This is the way it always is: it has been estimated that in the United States 20% of the beer drinkers drink 80% of all the beer sold. It is the serious drinkers that drink all the beer and they tend to drink to the bloat limit once they get started."

"I see," said the king, "but you haven't explained what this bloat limit is."

"The beer bloat limit is a physiological constant: the average human, your proverbial 70 kg man, is only capable of consuming three litres, or six 12 oz bottles of beer at any one sitting."

"Aha — that explains why our Peace Corp volunteers bring in their beer in six-packs," exclaimed the king.

"Right. Now, the significance of the bloat-factor is that you can use it to fine-tune your debit-credit balance: I must warn you that while you will be reaping a nice harvest of taxes (credits) from your state-santioned sao-ho, there will be inevitable social costs (debits) related to its consumption such as guano-truck accidents, family problems, decreased productivity, and so forth. The trick is to make sure the credits exceed the debits."

"How do you arrange that?" asked the king.

"You arrange that by legislating — or in your case decreeing — the amount of alcohol to be allowed in your sao-ho. To take the low road, you produce a standard beer with very little alcohol content: the advantage here is that your sao-ho drinkers will tend to bloat-out before they ever get close to pass-out; the bulk in the belly will force the drinker to cease before too many bubbles reach his brain. Since it is extremely difficult for citizens to get drunk on the stuff, this limits your debit payouts leading to a net gain for the treasury."

"Well, that's what I want," said the king, "a net gain for the treasury."

"Now wait a minute, I haven't told you the disadvantages of the low road. If people can't get off on the stuff they won't bother consuming it. They've had this problem in some American states."

"I see..... and if they don't consume it in quantity there go my tax revenues," said the king.

"Right, for although some of your citizens will go into special training, like American college students who stick at it until they can get inebriated on 3.2% beer, it will be a small number, since it takes a lot of practice and persistence."

"My people are too lazy to do anything like that," sighed the king, "I think we'd be better to take the high road.....how strong can we make new-improved sao-ho?"

"With a good yeast, you can get it up to 7% or 8%. In that case your average beer drinker will be able to flip-out well before bloat-out."

"What do I care as long as I get my taxes?"

"You're forgetting the debit side. The high road can be very costly because of the social problems: for instance, the province of Quebec allows on the market a beer in the 7% range and it has the highest motor vehicle accident rate in Canada — do you want your guano-truck drivers careening down the mountain like Montrealers coming off a boulevard ramp?"

"So what am I to do?"

"I suggest you shoot for the middle of the road with a brew in the 3.8% to 4.7% range. That's what most governments do: this is not so low the people won't bother drinking it, but not so high that the social cost is prohibitive. It provides a nice cheap drunk for a citizen with an average capacity bloat-factor wise."

"Is that important — the cheap drunk?"

"By tradition, every civilized country provides one cheap drunk for the masses; in most countries it is beer, in others it is wine, in some it is spirits. Even governments that are not elected are not so stupid as to deny their citizens at least one cheap drunk."

"What do you do in Canada?"

"We take the middle of the road bloat-factor wise. And we have always rigged the tax system so that beer is the beverage of the common man; ounce for ounce it is the cheapest alcohol on the market. Jean Talon planned it that way — he wanted to wean the Quebec colonists off brandy — and we have continued."

"And how are you making out?"

"From the actuarial point of view, we are not quite breaking even — when you total up all the debits, I mean."

"Then what's the point of having a brewery," asked the king, seeing his dream of a new Mercedes slipping away.

"I said from an actuarial point of view. In practice, we collect the credits, which are the alcohol taxes and the sales tax on those taxes, but we more or less ignore the debit side .....oh we support a little research and treatment and blow a few bucks on an advertising campaign now and then, but just enough to let the people know we are concerned, not enough to influence the balance of payments."

"Then who does pay the debits?"

"The people who drink the beer."

"Who are the very ones that pay the taxes," squealed the king with delight.

"Now you've got it," said the CIDA expert.

"You draw up the plans," said the king, "and I'll pick the site. And while we're at it we might as well get one of those other things too."

"Sure, any special kind of distillery you had in mind?"

* * *

(Wayne Howell is an Ottawa physician and freelance writer.)

Depression may underlie drug treatment failures

By John Shaughnessy

TORONTO — Many treatment failures in drug abuse programs may be the result of undetected and untreated depression, says Edward C. Senay.

Dr Senay, associate professor of psychiatry at the University of Chicago, bases his opinion on a study of 432 applicants to the Illinois Drug Abuse Program. Of this group, he said, 28% would be considered severely enough depressed to warrant specific treatment for their depressive symptoms.

Speaking to the American Psychiatric Association here, Dr Senay said establishing psychopathological diagnoses in drug abusing patients represents a special challenge because of the difficulty in separating drug-induced effects from underlying pathology.

"The chronic effects of narcotic use on mood, for example, is not well understood, and there is some evidence heroin use induces dysphoric states which may be mistaken for depression. The finding in our study that depression was present in both opiate and non-opiate dependent groups indicates the symptoms noted were, at least to some extent, independent of the type of substance used."

Dr Senay also found a higher level of psychopathology, including depression, among the non-opiate dependent group in his study, and this confirmed his impression that people with compulsive multiple drug abusing patterns are more seriously psychiatrically disturbed than people presenting with opiate addiction alone. "But it is possible that drug effects contributed to the higher psychopathology scored in the non-opiate addicted multiple drug abuser."

Dr Senay said he could find only one report on the effects of antidepressant agents in drug abusing patients. That study involved 35 methadone maintenance patients, and those receiving doxepin where judged to have had significant improvement in depressive symptoms compared to those receiving placebo. Dr Senay says this study combined with his own findings provides justification for a definitive controlled clinical trial of antidepressant drugs in depressed drug abusing patients.

Of the 432 applicants in Dr Senay's study, 266 were opiate dependent patients with histories of addiction of two or more years, 100 were opiate dependent with addiction histories of less than two years, and 66 were non-opiate dependent polydrug users. Sixty-seven percent of the sample was male and 64% was black.

Tests used to assess depression included the Current and Past Psychopathology Scales (CAPPS), the Hamilton Depression Rating Scale (HRS), and the Beck Depression Inventory (BDI).

With the first test, Dr Senay found marked elevations on depression-anxiety, impulse control, and summary role adjustment scales, and moderate elevations on the "reality testing-social disturbance and disorganization scales". On the BDI, 45% of the sample scored in the moderate or severe range of depression, and on the HRS, 28% scored above the mean for depressed psychiatric outpatients.

Dr Senay said the proportion of patients in each drug abuse group with elevated depression scores on the BDI was equal (45%), but the non-opiate dependent group had significantly more severe depressive symptoms. He noted too that depressive symptoms occurred at a higher rate in females than in males, but there was no relationship between depression scores and other demographic variables.

Patients in the study abused many different drugs. Following opiates, the drugs most frequently used on a daily basis were marijuana and alcohol, with the highest percentage of users of these drugs in the non-opiate dependent group. Benzodiazepines and other minor tranquillizers were used by about 9% of each group on a daily basis. Antidepressant drugs were used on a daily basis by only four subjects in the entire sample.

"Depressive symptoms were found in all drug use groups," said Dr Senay, "and our results indicate the need for psychiatric evaluation and specific treatment of depression in addition to the standard social rehabilitation measures in drug abuse treatment programs."

For pregnant women

Two drinks daily are risky

WASHINGTON — United States studies have confirmed that pregnant women who take two or more alcoholic drinks daily increase their chances of giving birth to mentally retarded and physically deformed babies.

Ernest P. Noble, director of the National Institute on Alcohol Abuse and Alcoholism, told a news conference here the most dangerous period for the unborn child of a heavy drinker is from three to four-and-a-half months after conception, and during the final three months of pregnancy.

Ernest Noble

He also said periodic binge drinking is more dangerous than drinking in moderation throughout pregnancy.

According to Dr Noble, the best scientific evidence indicates that two drinks a day or less produce no adverse effects. But "both the risk and the extent of abnormalities appear to be dose-related, increasing with higher alcohol intake during the pregnancy period."

Dr Noble said the NIAAA is circulating a "health caution" to doctors and health care facilities warning of the dangers of heavy drinking during pregnancy. The US Food and Drug Administration and the Center for Disease Control have agreed to include the warning in their publications for doctors.

The NIAAA estimates 1,500 of the three million babies born in the United States each year have "full-blown fetal alcohol syndrome" and probably several times that many have some symptoms.

The symptoms include babies with IQs between 60 and 70 — severe retardation; hyperactivity; heart murmurs and other cardiac abnormalities; a small head; low-set ears; small eyes; flat nose with upturned nostrils; carp-nosed mouth; poorly developed limbs; fingers or toes joined together, fingers constantly extended or bent at the joints; minor genital abnormalities; and strawberry birthmarks that are common in infancy.

Dr Noble said women who drink as much as six cans of beer, glasses of wine, or mixed drinks daily during pregnancy may have babies with all the symptoms of the syndrome, while those who take more than two drinks but fewer than six may produce children with one or more symptoms.

A mixed drink, as defined by the NIAAA, would contain about half an ounce of pure alcohol. That amount is the equivalent of one ounce of 100 proof vodka and slightly less than 1.2 ounces of 86 proof whisky.

Dr Noble said the scientific breakthrough linking alcohol intake and birth abnormalities came in 1973 when researchers in Seattle identified a pattern of defects in the children of chronic alcoholic mothers. Further studies have identified one or more of about 20 symptoms that occur in the babies of women who had more than two drinks a day — including mixed drinks, beer or wine, or who went on occasional binges during pregnancy.

Restrictions may lead to better record-keeping

(from page 1)

an accounting by the federal health minister.

For a pharmacist, the problems which could trigger a suspension of the supply of specified drugs include:

- violating a rule of conduct of the provincial licensing authority which causes the authority to request action by the federal health minister;
- being unable to demonstrate that all narcotics and/or oral prescription narcotics purchased or obtained by him or her have been furnished in accordance with the federal drug regulations;
- violating the federal regulations themselves.

Federal health department officials explain that the new regulations should provide incentive for pharmacists, doctors, and dentists to keep more adequate records of the narcotic and other restricted drugs under their control.

In effect, it will no longer be up to the government to prove beyond a shadow of a doubt that a pharmacist or medical practitioner has allowed drugs under their control to be misused.

In fact, pharmacists are also faced with a further new regulation warning that:

"No pharmacist shall sell a preparation (mentioned in the previous subsection of the regulations) where there are reasonable grounds for believing that the preparation will be used for other than recognized medical or dental purposes."

The "preparation" referred to is a non-prescription preparation containing up to eight milligrams (or equivalent) of codeine phosphate per tablet or unit (or not more than 20 milligrams per fluid ounce, in a liquid preparation).

The drugs covered by the new, detailed regulations include narcotics, oral prescription narcotics, exempted codeine compounds, controlled drugs, and controlled drug preparations, according to the officials.

Since the drugs are categorized, the government will have the option to "tailor" the restrictions on prescribing to the type and extent of the "crime."

Thus, if a pharmacist or doctor is mishandling only one group of the less harmful drugs, a restriction could be issued covering only those drugs unless and until there is evidence of mishandling of more potent narcotics.

The health officials also say that normally, the department will first consult with the appropriate professional licensing body before placing the name of a pharmacist or medical practitioner on the restricted list issued to licensed drug dealers.

In some instances, action by the provincial licensing authorities might be all that is required; in other instances, a provincial inquiry might uncover a plausible explanation for a seeming inability to account for all narcotic drugs, for example.

The government officials say the restricted list sent to licensed drug dealers each month usually contains the names of 75 to 100 professionals, many of whom are repeats each month.

Normally, the restrictions last for a year, and can be lifted thereafter on a written request from both the affected professional and the appropriate licensing authority.

The new regulations were scheduled to come into effect when they were published in the Canada Gazette, the government's official publication for new rules and regulations. The publication in the Canada Gazette was expected to take place in late June.

Papaver bracteatum vetoed in US

WASHINGTON — The United States government will not permit cultivation of *Papaver bracteatum.*

The government's decision was announced June 2 following two days of hearings on proposals to legalize commercial cultivation of the plant from which codeine may be processed. (Most codeine is produced now from the opium poppy, *Papaver somniferum.*)

Peter Bensinger

Peter Bensinger, head of the Drug Enforcement Administration, said the US has traditionally set an example of non-production of narcotic plants. "We cannot very well ask foreign governments to work to diminish world-wide supplies of illicit narcotic drugs, and then contribute to a weakening of international controls by allowing commercial cultivation here."

The State Department opposed relaxing the ban on cultivation because such a move would be an about face of US policy and would make international narcotic controls more difficult to maintain.

The Department of Health, Education, and Welfare argued there was no shortage of opiate raw materials and thus no need for commercial cultivation.

Spokesman for the medical profession and pharmaceutical manufacturers testified in favor of lifting the ban. They said such a move would stabilize the cost of codeine and assure the supply would be adequate.

Pot class bores students

STORRS, CN — Officials here seem more excited than students about a "how-to" class on marijuana growing being offered at the University of Connecticut.

The course has provoked worried comment from the chairman of the university's Board of Trustees and from the governor of Connecticut.

But it appears the course, scheduled to begin this month at an experimental branch of the university, might be cancelled for insufficient registration.

That did not appease the chairman of the university's Board of Trustees, Gordon Tasker, who asked the university to prohibit the course.

It is a crime in Connecticut to grow marijuana and Governor Ella Grasso has questioned the wisdom of using university facilities to teach students how to commit a felony.

College officials have said no marijuana would be present during the class.

This, according to some students, is the reason why they've shown little interest.

'You shall not reap what you have sown'.

It'll be gone within a decade

Chafetz predicts cigarette smoking will soon end

By Manfred Jager

WINNIPEG — The day when cigarette smoking is a thing of the past, may not be far away, says a noted United States psychiatrist. And the same fate may befall liquor consumption — all because of a growing social unacceptability.

Morris E. Chafetz, a principal research scientist at Johns Hopkins University Centre for Metropolitan Planning and Research in Washington, DC, and a former director of the US National Institute on Alcohol Abuse and Alcoholism, was speaking to the national conference of the Royal Life Saving Society of Canada at the University of Manitoba.

Morris Chafetz

Cigarette smoking, said Dr Chafetz, will have passed from the scene within a decade.

Its demise, Dr Chafetz predicted, will coincide with an equally dramatic change in western society which will almost certainly eradicate alcohol abuse and make deep inroads into the very use of liquor.

Dr Chafetz, president of the American Health Education Foundation, said modern western man has labored for decades under the "puritan aspects of guilt, conflict, and ambivalence in connection with alcohol, this ages-old substance which gives us both pleasure and pain.

"We have tended to confuse the moderate use of alcohol with excessive use. We forget that the use of everything to excess is destructive."

Dr Chafetz said there has also been a good deal of ignorance, and individuals as well as societal groupings up to the size of entire nations, prove time and again that the heavier the use of alcohol, the less the people responsible for the abuse really know about alcohol.

"In those countries which know the least about it, and how to use it, you find the greatest incidence of alcohol problems in the world," Dr Chafetz said.

"The heavier the drinker, the less knowledge he or she has about the effects of alcohol. And we know very little about alcohol."

Yet, there are societies with next to no alcohol problems, the psychiatrist said.

"They are the societies in which alcohol is the part of, rather than the reason for, anything, where words such as cocktail party, cocktail dress, beer bash, and so on, have never even entered the language, even though alcohol has always been the drug of choice in society."

The second reason for the almost complete absence of alcohol problems in some countries is the fact drunkenness in these countries is absolutely frowned upon as being totally unacceptable, and particularly as being unworthy of a male, Dr Chafetz said.

"We, on the other hand, seem to think that alcohol overuse is humorous. We laugh at the drunk and it is, really, like laughing at someone with an epileptic seizure.

"We actually laugh at someone whose brain is so unaesthetized that they stagger, slur their speech, lose the ability to exercise their judgment. And I know, and you know, certain performers, who do their thing, who make their living, by acting drunk, by acting as if overdosed with this drug — and earn gales of laughter from thousands of people watching them and getting a giant kick out of it.

"When you laugh, you may get rid of your own tensions, but you also approve.

"If I came to any of your homes and you served me food and made me ill, you'd be mortified. But if I come to your home and you serve me — either through your generosity of through my own greed — alcohol, and I'm sick the next day, or get smashed up in my car on the way home, you don't feel mortified and embarrassed for some reason."

Dr Chafetz said the social context in which a drug is taken, however, very much affects the outcome.

"Let me give you an example: All things being equal, if I take a given dose of alcohol and I go to a function at the White House, my response on that given dose of alcohol will be quite different than if I drink it with a fraternity brother of mine.

"What's different? There are no signs on the walls of the White House telling you how to behave. But there are transmitted certain rules of behavior. I guarantee you that if somebody took an entire fifth of booze and drank it in the White House, they would still behave well."

Dr Chafetz added: "When someone you know begins to overdose alcohol, instead of pointing the finger at that individual, ask yourself 'what did I transmit to give them the permission to do so.'

"You must realize how we all behave as we do — not from rules, not from regulations, not by affirmations, not by laws. We behave to the limits that we do because there are few people whose approval and acceptance we must have, who let us know how far we can go in our behavior. That and nothing else is what limits us."

Turning to the tobacco industry, Dr Chafetz said: "The tobacco industry is terrified about one new development in the United States. They are not concerned that they were banned from the broadcast media to advertise their wares, or that there have to be warning messages on the packages, or that taxation on cigarettes has shot up.

"What they are concerned about is that there is a movement in the United States, and in other parts of the world now, to make smoking socially unacceptable. That's beginning to worry them, because it is that kind of social response that produces social change."

Stimulants 'definitely allow venting of violence'

(from page 1)

up for murder because of the way they felt or what they believed at the time.

"They still had that millimeter of control that's left before you really blow it."

Dr Asnis realizes many researchers do not believe amphetamine abuse can lead to such violent behavior. "I think, though, that these are people who have not spent much time with violent people who use the drug."

At this particular time, "I am not sure which comes first, the propensity to violence, or the drug abuse.

"But it seems the stimulant drugs definitely allow the expression of violent behavior just by the symptoms they produce: agitation, stimulation, paranoid thoughts, very faulty and poor judgment, and delusions that people are doing something to them."

This was the pattern of behavior that led to death row for one man in his 40s who had been a chronic amphetamine abuser for six or seven years. He reached a point finally where he took 2,000 mg to 3,000 mg of amphetamine a day for several weeks.

He started to believe that beings from outer space were shooting him with laser beams. He knew exactly when lasers were being used because his skin started to itch.

He armed himself and searched for those using the lasers. He knew when he found one: when he turned around they were looking at him.

A number of people, young and old, were killed, and more wounded, in his rampage of violence and death.

Since the prisoner has been at San Quentin, he has been able, on several occasions, to get his hands on asthma drugs used in the prison hospital. "He takes 25-30 tablets, just like that, and he says it makes him feel better," Dr Asnis adds.

Another death row prisoner, while on a high dose amphetamine run, became convinced, falsely, that his girl friend was unfaithful. Three people died and four others were wounded following his outburst of rage.

Dr Asnis says the pattern among the high dose abusers is similar. "They became increasingly suspicious, nervous, anxious, and increasingly positive people were against them.

"Some of them have told me they heard voices telling them to beware of a specific person or situation.

"A very common complaint is that their skin itches. One man showed me the scars he had made while trying to excise what he thought were crystals that had entered his skin."

Dr Asnis has observed a similar pattern among people brought to the hospital in San Francisco while under the influence of amphetamines. They have areas of the body that itch and they often pick at their face.

Pupils are dilated and often there is a constant gnashing of teeth.

Dr Asnis emphasizes the violent inmates "don't just take a few amphetamine tablets and then go beserk. They have usually been chronic abusers and build up their tolerance.

"With high dosage, say 1,000 mg to 3,000 mg a day, I think within a few weeks they are able to develop those crazy ideas."

As the run continues, mistrust and agitation builds. Tempers explode, the abusers become very argumentative and loners "as not many people want speed freaks for friends," Dr Asnis adds.

Most of the abusers also have a drinking history and many mixed alcohol and amphetamines, while others turned to alcohol near the end of a run.

Often they would go seven or eight days without sleep, not eat, and consume two or three bottles of alcohol.

Dr Asnis says the mixture of alcohol and amphetamines is particularly dangerous: "It is like the amphetamines give them the push and the alcohol loosens them up to do it."

He is still not clear, from the conversations, whether the prisoners who were most violent committed their actions while taking both drugs.

"However, my impression is that you don't have to have alcohol to be very, very violent, homicidal, and to have poor control and unpredictable behavior behind amphetamines."

Many prisoners claim that while on a run they drink prodigious amounts: a bottle of tequilla, for instance, without falling down or blacking out. Yet only half that amount would knock them out when they were not on drugs.

"They seem to metabolize it differently, or possibly it is something that affects the autonomic nervous system. But whatever happens, I am sure it has not been studied fully."

Dr Asnis has found among his San Francisco patients that cocaine users report they wind up drinking a lot more alcohol than usual while on a run.

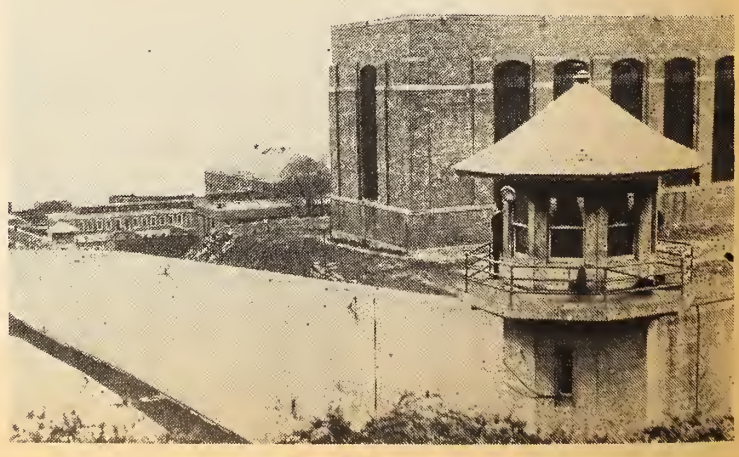
In the case of heroin abusers, most say they would rather not drink when they have the drug. But if they have no heroin, or are on methadone or other therapy, then they turn to alcohol to get high.

Dr Asnis has no fixed idea yet on how the prisoners became such extreme amphetamine abusers, but it seems most have a polydrug background.

Dr Asnis says the fine line that many stimulant abusers walk was illustrated at San Francisco jail recently when a man was brought in "who was very combative and doing karate stances because he believed the guards were out to kill him.

"It wasn't known then that he had taken a very large dose of Ritalin, another drug in the stimulant group, which produces effects similar to amphetamine.

"It took seven guards to subdue him finally. It was only the circumstances, I guess, that prevented him from being a killer."



San Quentin Prison

OMA aids doctors

By Betty Lou Lee

TORONTO — The Ontario Medical Association is going to help the province's doctors cope better with alcoholism — both their patients' and their own.

In cooperation with the Addiction Research Foundation of Ontario, the OMA has prepared a 40-page booklet on how to treat alcoholics and where to refer patients for more help. It will be available this summer.

Dr John Slater of Cochrane, chairman of the OMA public health committee, described the booklet as "an attempt to get some order into chaos."

Doctors have had inadequate training about alcoholism during their years in medical school, but alcohol is related to 20% of hospital admissions in Ontario, he said.

He wondered if the Ontario figure wouldn't be closer to France's 50% "if there weren't a big coverup going on", where patients are admitted with a diagnosis that doesn't mention alcohol.

At its annual meeting in Toronto, the OMA also decided to set up a special advisory group to help doctors with drinking problems before they get in trouble with the Ontario College of Physicians and Surgeons. Its main function will be to advise these doctors, or their worried colleagues, where help is available.

Neil S. McLeod of Thunder Bay, chairman of the OMA committee on medical care and practice, said fewer than 10 doctors a year come before the College each year because of alcoholism, but the problem is much larger than that. They only appear for disciplinary action when their competence has been affected.

"We want to help them before they get themselves into the problem with mistakes and errors."

Doctors are often reluctant to go to facilities in their own communities — many of them are treating alcoholics they might meet there. He said many of them are unaware that institutions like Homewood in Guelph have particular experience in treating professionals who are alcoholics.

Narcotic addiction among doctors is more easily dealt with, Dr McLeod said. They are usually brought to the attention of the College by the RCMP through checks on prescribing habits, and the College can curtail prescribing privileges.

"This is fairly well looked after in a voluntary way, and we're reasonably happy to leave it alone."

Dr Slater's committee also recommended that the Ontario drinking age be raised to 19, and the OMA board of directors will consider the recommendation. There is no official OMA policy at present on raising the age.

VA moves to stem criticism from other agencies

By John Shaughnessy

WASHINGTON — Veterans Administration officials here are taking steps to improve the VA alcoholism program and to stem the criticism levelled at it by other government agencies.

Seventy-eight specialized alcohol dependence treatment programs are now in operation in the Veterans Administration health care delivery system and requests are pending to start 81 more when funds become available.

Max Cleland, newly appointed VA administrator (in March), told a press conference here that this is the largest alcoholism treatment program under single management in the United States. He said alcoholism is the number one health problem in the VA hospital system, and that an estimated three million veterans suffer from alcoholism or alcohol-related problems.

In 1974, VA hospitals treated and discharged about 157,000 veterans for alcoholism or alcohol-related problems. Alcohol treatment units treated about 47,900 of these veterans as inpatients.

Despite this, a 1975 report to Congress by the General Accounting Office (GAO) was critical of the VA alcoholism program and recommended several changes. It said that while the VA has made progress in its alcohol treatment program, the overall effect has been low.

"VA has not established overall program goals or provided central operational direction to the units. Nor has VA made the necessary commitment toward developing a comprehensive program for veterans with alcohol problems. Some of the most populous metropolitan areas with VA hospitals have no treatment units and no plans for any."

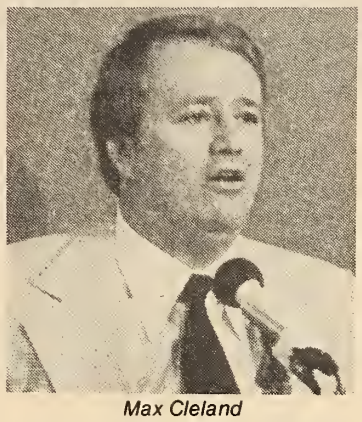
Other criticisms in the report included:

- The availability of VA alcoholism services has not been adequately publicized.
- Veterans diagnosed as alcoholics upon admission to VA hospitals for other medical treatment usually were not referred to, or contacted by, alcohol treatment units staff located at these hospitals.
- Treatment programs have not generally been designed to meet the needs of working veterans.
- Inconsistent admission criteria have been applied by the units and supporting services have not been emphasized.
- VA lacks an evaluation system to find out how effective the treatment units have been.

Since that 1975 report, the VA has made several changes in its program and, at the press conference, Mr Cleland gave a progress report on the VA's efforts to implement the GAO recommendations.

The GAO recommended the VA improve its management of the alcohol dependence treatment program by establishing overall program goals, including criteria for establishing treatment units, providing operating guidelines for them, and developing performance measuring standards and procedures.

Mr Cleland said the "VA has adopted as an objective of management a program capability for each VA health care facility to respond to the broad spectrum of substance abuse conditions, with early implementation of an individualized treatment plan for each veteran with a substance abuse problem."



Max Cleland

In 1975, 19% of all patients discharged from VA hospitals were diagnosed to have either alcoholism or alcohol-related diseases. On October 1, 1975, in all VA hospitals, 22.5% of all patients were identified as alcoholics or problem drinkers.

But a statement released at the press conference indicates the VA currently has 89 medical facilities, which have the general capacity for supporting specialized treatment of such disorders, and which do not now have such programs.

Mr Cleland said the management objective, when funded by appropriations, will provide fully adequate quality service in crisis intervention, differential diagnosis, specialized treatment, rehabilitation, and ambulatory care of veterans in each of the VA hospital catchment areas.

Each medical facility has already received specific policy guidance on treatment goals to be addressed in the care of alcohol dependent veterans. A program guide for the Alcohol Dependence Treatment Program is in the final stages of review and should be published and distributed to the field within the next few months.

This programs guide, said Mr Cleland, along with the revised Mental Health and Behavioral Sciences Manual, and the national standards for alcoholism programs developed by the Joint Commission on Accreditation of Hospitals, with VA participation, should provide ample guidance to all VA personnel regarding the care of veterans suffering from alcoholism or alcohol abuse.

Concerning the lack of treatment units, Mr Cleland said that as of December, 1976, only six populous cities with VA hospitals do not have Alcohol Dependence Treatment Programs. "These cities — Dallas, New Orleans, Kansas City, Cincinnati, St. Louis, and Cleveland — are in our first priority for activation when appropriated funds are made available."

To increase awareness of the alcoholism treatment services, the VA this year distributed 150,000 copies of a brochure to VA hospitals, outpatient clinics, veterans benefit offices, and various service organizations. In addition, an "outreach program" begun in 1974 to identify and encourage veterans with alcohol and other drug abuse problems to seek and remain in treatment, has produced encouraging results — a 67% increase in contacts from 1975 to 1976.

"The brochure, the outreach program, and the use of other pamphlets distributed by the VA, have brought a steadily increasing number of veterans into VA's health care facilities for treatment and rehabilitation of alcoholism and other substance abuse problems," said Mr Cleland.

To correct deficiencies in evaluation, the Systematic External Review Program (SERP) of the VA as well as the Systematic Internal Review (SIR) activity, carried out under the auspices of the Health Care Review Service of the Assistant Chief Medical Director for Policy and Planning, "currently provide important information on the efficiency and effectiveness of the VA alcohol dependence treatment programs".

This year, the Management Engineering Service of the Assistant Administrator for Planning and Evaluation is undertaking an extensive evaluation of the alcohol and drug dependence treatment programs of the VA centering on treatment and program goals and the extent to which those goals are being reached.

More specifically, the VA has completed a six-month followup of a sample of alcoholic patients admitted for treatment at 17 VA locations between July 1 and Dec 31, 1975. Analysis of the findings is expected early next year, comparing health and socio-economic functioning of patients on admission and at followup to see what progress has been made in reaching the VA's treatment goals.

The VA is also evaluating a sample of over 600 of the veterans in the six-month followup referred to above, evaluating them at approximately 24 months after their entry into treatment.

Finally, using these studies as the basis for future evaluation efforts, the VA is planning a follow-up study of a representative sample of patients admitted to all 78 of its current alcohol dependence treatment programs. This study, says the VA, will incorporate the trends and significant variables identified by the previous studies of the effectiveness of treatment of alcoholic veterans, will conceptualize an updated plan of treatment outcome and program evaluation, will produce new data base instruments as necessary for the gathering of data at a time of admission and followup, and will follow a sample of 30 patients in each of the programs at one-year, two-year, and three-years points following initial admission.

Liver injury test promising: Lieber

(from page 1)

after cessation of alcohol intake.

"Thus far," said Dr Lieber, "we have had very encouraging results in detecting unsuspected heavy drinking and also in terms of monitoring patients who are undergoing treatment. We hope this will give us an objective way of diagnosing heavy drinking at the early stages — prior to the medical and social deterioration of the patient."

A second test, developed at the hospital, is designed to detect those patients in whom alcohol intake is heavy enough to affect the liver severely. Dr Lieber said conventional liver tests are not specific enough to detect liver damage due to alcohol.

He said alcoholic liver injury is characterized by a severe involvement of the mitochondria and he and his co-workers wondered whether components of the mitochondria might serve as a measure of alcoholic liver injury.

With this as a starting point, the team measured the appearance of glutamate dehydrogenase (GDH), which is exclusively mitochondrial, in the blood of alcoholics and compared it to the presence of lesions that develop in the liver. Dr Lieber said the team found an excellent correlation between blood levels of this enzyme and the degree of liver necrosis in the alcoholic.

"We are hopeful we now have a useful blood test for the detection of liver injury in alcoholics," he said.

He noted that a still unanswered question is which alcoholic patients with liver disease will go on to develop cirrhosis. Animal experiments with baboons at the hospital have provided some clues.

Dr Lieber found that some "alcoholic" animals had pericentral sclerosis in the liver (scarring around the central vein). He said this is not normally present, and after following these animals over a six-year period he discovered that animals which were already in the fatty liver stage and had this lesion went on to develop cirrhosis. Those without the lesion did not.

"We are in the process of determining whether this pertains to our human population as well," said Dr Lieber. "We found that a significant percentage of our alcoholics have this lesion at the fatty liver stage, and if we can verify the evolution towards cirrhosis we may have a tool to segregate in our alcoholics those that have a propensity to develop cirrhosis."

CFADD to switch to CAF

OTTAWA — The Canadian Foundation on Alcohol and Drug Dependencies may change its name to the Canadian Addictions Foundation.

The advisory board of this private agency has approved the new name because the present title is too long and cumbersome, according to executive director of the CFADD, Francoise Berthiaume.

The name won't be changed officially, however, until the membership agrees to accept it, the vote to take place at the CFADD's annual meeting this month in Winnipeg.

Alcohol withdrawal need not be an emergency

WASHINGTON — The alcohol withdrawal syndrome need not always be classified as a medical emergency, says James L. Stinnett.

Dr Stinnett, chief of the alcoholism treatment unit at Philadelphia Veterans Administration Hospital, told a press conference here that traditionally the alcohol withdrawal syndrome has been associated with hallucinations, seizures, and in some cases delirium tremens and mortality. As a result, the usual approach to treatment involved hospital admission with close medical and nursing supervision.

James Stinnett

However, this approach has caused problems, and new techniques are being developed to deal with the syndrome.

The main problem, he said, is there are more patients than available facilities. In addition, since detoxication is the first and one of the most important steps in the rehabilitation of an alcoholic, the negative social stigma associated with being a hospitalized alcoholic should be avoided where possible.

There is also some concern that a hospital provides an unnatural protected environment, and treatment successes there may prove illusory when the patient returns to his home situation.

Further difficulties with hospital based treatment of the alcohol withdrawal syndrome are that it often fragments the total treatment delivery to the alcoholic and it is a questionable procedure in terms of cost effectiveness.

Dr Stinnett said all alcoholics do not have to be admitted to hospital for treatment of the alcohol withdrawal syndrome. "If it is medically safe, they can often be treated as outpatients."

To overcome some of the problems involved in in-hospital treatment of the syndrome, he has set up an outpatient medical detoxication unit at the Philadelphia Veterans Administration Hospital.

The program is designed so patients are seen every day, and given only a single day's supply of medication (usually Librium or Valium) at a time. Patients are also given a daily breath test "for medical reasons only."

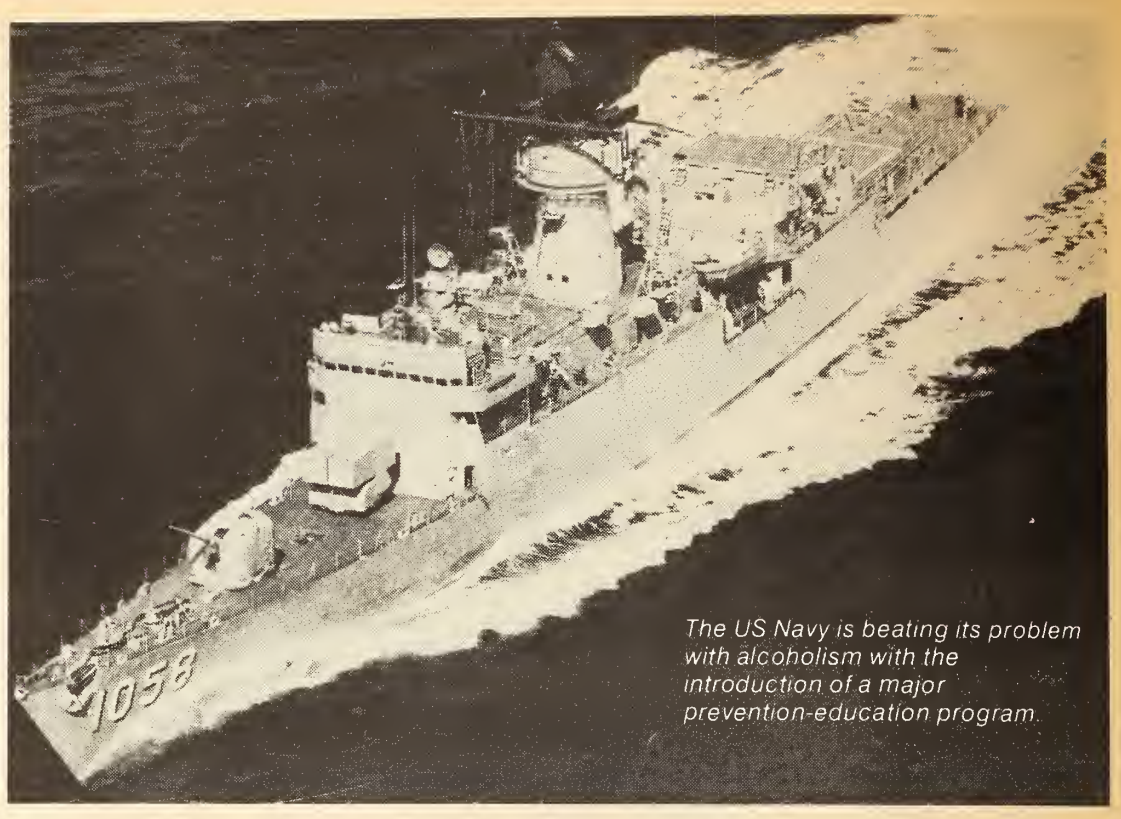
Dr Stinnett said patients are followed until they are through withdrawal or detoxication and then "plugged into" outpatient followup programs at the same clinic and involving the same personnel. This, he noted, cuts down on the number of patients who drop out of the rehabilitation program.

To date, about 75% of patients in the program have completed their detoxication, and there have been no seizures, serious medical problems, or DTs in the patients involved.

Advantages of the program are that it allows treatment of more alcoholics; it allows the alcoholic to remain with his family and decreases the social stigma; and it facilitates continuity of care. A few patients have even continued working while involved in the program.

Dr Stinnett cautioned, however, that the program is not a panacea. It is safe and effective for the majority of alcoholics, but not all. If a patient has a serious medical problem such as a seizure disorder in the 24-hour period prior to admission, a history of head trauma or myocardial infarction, he is not allowed to participate in the outpatient program, but is admitted to hospital.

US Navy is learning what to do with its drunken sailors



The US Navy is beating its problem with alcoholism with the introduction of a major prevention-education program.

SAN FRANCISCO — The United States Navy's major problem with alcohol abusers has been met head on with a prevention program that has achieved major success.

The Navy Alcohol Safety Program (NASAP) has made an important impact on the Navy's annual rate of deaths, injuries, and property damages resulting from alcohol-related incidents and accidents, Commander Gerald Bunn, coordinator of NASAP, said in a paper presented here to the National Drug Abuse Conference.

The prevention program has experienced a recidivism rate equal to or better than the civilian experience of 7%, Commander Bunn stated.

"The Navy has a considerable problem, and there is a great and a real need for an action program, such as NASAP, to provide management with a resource to enable commands to enjoy higher operational efficiency," he added.

The extent of the problem was outlined in statistics presented by Commander Bunn:

Based on data collected by the Naval Safety Center in 1976, alcohol-related accidents involving naval personnel resulted in 123 deaths, 466 injuries, and approximately $9.3 million in costs due to property damages and personnel losses. These figures related only to motor vehicle accidents and accidents at work or on liberty. They do not include naval air accidents in which alcohol was involved.

Of the total naval motor vehicle accidents in 1976, there were 229 deaths and 1,547 injuries. Of the deaths, more than 49% or 114 were alcohol-related. This is an increase of 14% since a 1974 study of alcohol-related cases. An additional 25% of these fatalities were in the "unknown" category in reference to the involvement of alcohol. Only 26% of the fatalities were not alcohol related. The costs of these traffic accidents was $7.4 million due to deaths and $872,000 due to injuries.

"We feel these are conservative figures because we know that at least 50% of all fatalities on the nation's highways involve alcohol," said Commander Bunn. "We also know from our studies that the military drinking habits are at least equal to those of a similar demographic breakdown in the civilian community."

More statistics:

A 1975 study by the Bureau of Social Science Research surveyed the drinking habits of 10,000 anonymous active duty members of the Navy. Thirty-seven percent of enlisted men, 19% of male officers and enlisted women, and 9% of female officers reported having experienced problems with alcohol ranging from "critical" to "serious."

In San Diego, where the national headquarters of NASAP are located, during 1976 an average of 600 Navy people were arrested each month for an alcohol-related offense; 250 of these were for driving while intoxicated.

In 1976, there were 71,340 man-days lost because of accidents at work or while on leave or liberty. There were nine deaths and 87 serious injuries representing a loss of one million dollars.

"Again, we believe these figures are conservative because of the insufficient reporting of alcohol as the causative factor," said Commander Bunn.

Of deaths from alcohol-related work or liberty accidents, 58% occured by drowning, about the same percentage as for civilians. While death by drowning occurs in both the Navy and civilian life while swimming or boating, it more often occurs in the Navy while returning to the ship after liberty and falling off a pier, or out of the liberty boat.

The first NASAP class began as a pilot project in Pensacola, Florida in Sept 1974, and its success (of 600 graduates, the recidivism rate has been less than 5%) warranted the opening of a second site at Norfolk, Virginia. The third opened in San Diego in Oct, 1976, and by the end of 1977 there will be a total of 11 detachments.

"We feel the costs of running NASAP are quite reasonable when you consider the return in human life and productivity, and the higher cost of rehabilitation. While it costs only $170 per student in the NASAP alcohol education program, the cost for rehabilitation varies from $850 to $2,700 per person depending on the length of stay, and the treatment facility involved.

"NASAP has gotten off to a very productive start. It can, and has provided a much needed service to our own Navy people and it has improved relationships within the civilian community," Commander Bunn concluded.

Cohen urges study of solvent abuse by young

TORONTO — Some people will experiment with almost any substance to change their sober consciousness, but why young people in particular choose to sniff solvents to get high must be studied in order to begin curtailing this form of drug abuse.

Sidney Cohen, clinical professor of psychiatry at the Neuropsychiatric Institute at the University of California, Los Angeles, said he has observed seven major reasons why patients choose solvents as their vehicle of getting intoxicated.:

- Peer group influence: "Not only does the group dictate whether solvents or aerosols are to be used, but even which brand is currently favored and how to use them. If the crowd one goes around with are inhaling something, it is very difficult for any individual group member to abstain."
- Cost effectiveness: "Many inhalent abusers are from low income families and the price factor is a decisive element for some of them. A .75¢ can of varnish remover can intoxicate more people than a gallon of cheap wine."
- Easy availability: "Although alcohol is commonly assumed to be the most widely available of all intoxicants, in fact, industrial solvents can be found even in places where alcoholic beverages do not penetrate. In poor households a stockpile of liquor hardly is to be expected, but gasoline, paints, and a variety of aerosols are somewhere around."
- Convenient packaging: "A tube of airplane cement or a bottle of nail polish remover can be concealed much more successfully than a pint of wine or a six-pack of beer. The compact packaging is particularly convenient for those who still attend school and like to sniff between classes."
- Mood elevation: "Consistent users are treating their feelings of frustration and depression with the state of oblivion that the vapors from some solvents can bring. They appear unable to enjoy their life situation sober, either because of some personal inadequacy, a miserable family situation, or a deplorable social setting."
- The course of the intoxication: "The inhalation route produces a more rapid onset since it bypasses the gastrointestinal tract and liver, and delivers the solvent directly to the brain from the lungs. A further advantage mentioned by one client was that the drunk was over in an hour or so, rather than lasting all day as with alcohol."
- The legal issue: "Only one person mentioned the fact that buying or being in possession of some spray can or other solvent is not illegal. The legality of solvents versus the illegality of marijuana or alcohol for this age group does not seem to be an important consideration."

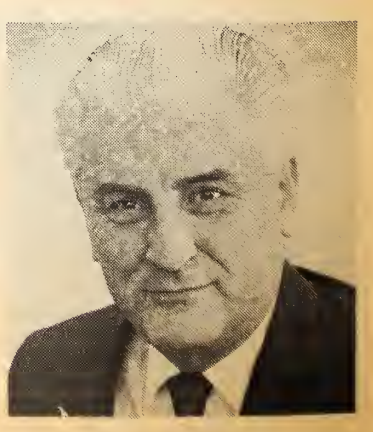
Dr Cohen, who was speaking here at a seminar on Solvents, Adhesives, and Aerosols said the pattern of use of these materials has changed.

"At one time, it could be stated that the abusers of household solvent preparations were adolescent males generally from some minority, low income group. Increasingly, females and young adults in their 20s are being identified as sniffers."

He said health education to reduce the numbers of young people who will expose themselves to these exotic chemicals will have to start at a very young age, and that everyone has a responsibility to make access to solvents as difficult as possible.

"Interestingly, developments outside the field of drug abuse may help the situation. Our concern with flurocarbon aerosols injuring the trophosphere might also accomplish their abolition as intoxicating agents. Similarly, the current move to remove lead from gasoline will reduce the instances of lead encepholopathy and lead polyneuritis in our gasoline sniffers."

Concluding, Dr Cohen stated: "A final solution will consist of corrective family and school experiences that will make solvent use irrelevant. Somehow, the self image of these young people will have to be enhanced. We cannot depend entirely on external controls. Only the development of internal controls will provide an assured solution to the problem of solventism."


Sidney Cohen

Role problems cause girls to drink

NEW YORK — Much of the drinking among teenage girls today evolves from a clash of roles in society in the fight for equality.

This is the view of Pereta Balain, who worked for four years helping to develop comprehensive health services for women before joining the National Institute on Drug Abuse recently.

Ms Balain told a workshop at the American Orthopsychiatric Association conference here that a particular concern has been teenage drinking. She has also had contact with many feminist groups.

She finds that for the white teenage woman "the feminist movement, although it has many positives, has not established psychological roots for the female to be able to call upon to use in terms of crisis situations or confrontation situations."

Without this base "and the understanding that independence creates in the male counterpart, basically she is out there by herself." The drive for equality is a double-edge sword as a young woman tries to assert her independence.

Ms Balain asked how many young women can deal adequately when told: "I've got no problem with your independence. . .but 'I'm busy tonight,' 'I'm going to promote so and so,' or 'you can't play on my team.'

"There aren't too many who can say: 'Okay, I may not play on your team, but I will come up with my own team'."

In the minority communities, the problem is compounded. "They can't even buy themselves into the system to create an atmosphere of equality, so then you have the escapism that comes from starting to drink," Ms Balain added.

In the field of teenage drinking, Ms Balain said most of those in the treatment field are moving away from reporting almost automatically the first contact a young person may have.

Travellers wage air war

DALLAS — The 40,000 members of the Airline Passenger Association have sat in a lot of smoke-filled airplanes, since they average more than 40 flights annually.

As a result of this experience, a members survey shows strong support for banning cigar and pipe smoking altogether.

"Approximately 11,000 responses have been received from APA members", the association reported. "By a three to one margin, APA members indicated that the current separation of smokers and non-smokers is a satisfactory arrangement.

"However, many members voiced a desire for stricter enforcement of the present rules. Also, the membership voted two to one in favor of banning cigar and pipe smoking altogether. The vote on banning smoking on shuttle flights was very close — just barely favoring allowing smoking."

The membership was more lenient when it came to the question of segregating drinkers. They did not vote to segregate this group.

Psychiatric patients should have drug screening

By John Shaughnessy

TORONTO — Psychiatric outpatients who covertly abuse drugs significantly reduce their chances of benefiting from therapy.

A study reported to the American Psychiatric Association here leaves unanswered whether covert drug abuse is a cause of psychiatric difficulties or follows the tension of psychic conflict. But it does suggest that, unless the abuse is known to the therapist, improvement in the patient's condition is unlikely.

Richard Hall said although drug abuse is perceived as a major problem of adolescents and young adults, his study suggests it is often responsible for psychiatric symptoms in patients aged 30 to 40.

"Such patients are less apt to report their drug abuse and consequently more likely to have psychiatric symptoms explained as having resulted from a major psychotic impairment. Patients who generate uncertainty in the diagnostician's mind are often labelled schizophrenic without the usual indicators of that illness being present."

Dr Hall, assistant professor of psychiatry at the University of Texas Medical School, Houston, also found that if drug abuse is not considered when the patient enters treatment, it is unlikely to surface as an explanation for symptoms during therapy unless the patient discloses its presence.

Even when physical manifestations, which might have suggested covert drug abuse, were noted on interview or physical examination, they were attributed to other causes and were not used to substantiate a definitive diagnosis including current substance abuse.

Dr Hall recommends that urine drug screening be routinely performed to identify covert drug abusers.

Dr Hall's study had a three-fold purpose: to ascertain the incidence of covert opiate, methadone, barbiturate, cocaine, and amphetamine abuse in a general psychiatric outpatient population; to assess therapists' ability to recognize covert abuse; and to compare the management of covert abusers with the management of patients with similar diagnoses who were not covert drug abusers.

Of 195 consecutive psychiatric outpatients surveyed, 26 (13.3%) were found by urinalysis to be currently abusing one or more of the reference drugs. Four were abusing only opiates, five only methadone, six only barbiturates, two only amphetamines and nine were abusing two or more of the drugs simultaneously.

Forty-six percent of the laboratory-proven abusers gave negative drug abuse histories, and Dr Hall found no demographic variable or historical item that predicted actual covert abuse.

He did find the incidence of adverse drug reactions to prescribed medications was statistically higher among covert abusers than non-abusers. Further, "the course of therapy was clearly affected by drug abuse with 56% of the non-abusing population considered unchanged in a three-month period, compared to 81% of the abusing population. Covert abusers were one-third less likely to improve with therapy than were non-abusers."

Dr Hall said therapists' skill and behavior were significantly affected by the patients' covert drug abuse. "Misdiagnosis of proven covert abusers was statistically higher than for non-abusers, and a large percentage of the covertly abusing population was diagnosed as suffering from schizophrenia or depressive neurosis."

On review, said Dr Hall, the schizophrenic diagnoses for covert abusers were judged inappropriate in 100% of the cases, while this was true of only 14% of non-abusers similarly diagnosed. The rate of misdiagnoses for depressive neurosis among abusers was twice as high as the rate among non-abusers. Overall, 85% of the covert drug abusers were misdiagnosed, compared to 23% of the non-abusing patients.

Dr Hall said 57% of the proven covert abusers received extensive medical evaluations indicating diagnostic confusion, but in no case was urine screening performed to ascertain if hard substance abuse was a diagnostic factor.

In his view, urine screening is the simplest and most efficient tool for the diagnosis of substance abuse of the opiate, barbiturate, methadone, and amphetamine types. "Such drug screening should be used to screen all new patients on admission and in cases where diagnostic confusion exists."

It may be fairly common in urban areas

Kidneys fail some amphetamine users

By Thomas Hill

DALLAS — Within the past couple of years, doctors have seen a new and potentially fatal syndrome in people who inject amphetamines.

Its main features are fever, shock, muscle death, and widespread clotting of blood in the vessels (disseminated intravascular coagulation). In many instances acute kidney failure develops.

Drs William C. Kendrick, Alan R. Hull, and James P. Knochel, three kidney specialists at the University of Texas Southwestern Medical School at Dallas, recently reported on five cases they treated in a six month period.

They've seen approximately the same number of additional cases since writing their report, Dr Knochel told **The Journal.**

The Dallas specialists suggest the syndrome may be fairly common, at least in urban areas where intravenous amphetamine use is a significant problem.

All five of the patients described in the report in the *Annals of Internal Medicine* (Vol. 86, p. 381) were chronic intravenous drug users. The amount of amphetamine they'd injected just before developing their acute illness, was no more than they'd previously used intravenously without adverse effects.

But this time — within 15 minutes — they began to have shaking chills, fever, profuse sweating, nausea, vomiting, diarrhea, and muscle pain.

In most cases, their urine turned coffee-colored and the output of urine was greatly reduced. One of the five actually had no urine output at all in the 24 hours before being taken to a hospital.

The amount of time between the start of their illness and their arrival at hospital varied. The minimum was 24 hours, the maximum 60 hours.

During this time they were hyperactive, as would be expected with amphetamines; they couldn't sleep; and they had recurrent shaking chills.

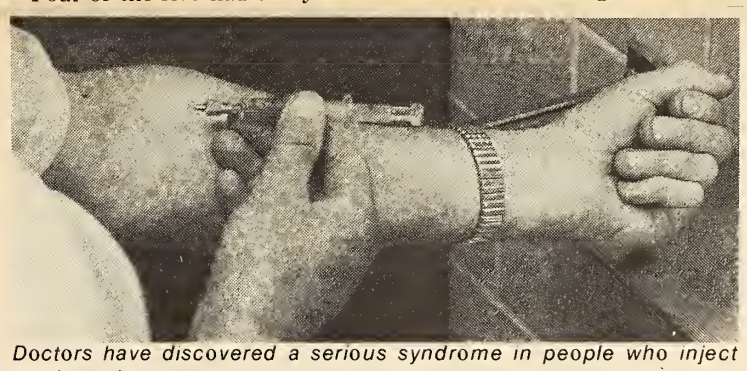
When admitted to hospital, all were judged acutely ill. All had fever and marked prostration.

Four of the five had tachycardia (rapid pulse) — the lowest 112 and the highest 132 beats per minute. The fifth patient had no pulse; he was comatose and not breathing when brought to the hospital emergency room.

Four of the five had signficant muscle tenderness. Three were jaundiced.

Laboratory tests confirmed certain clinical evidence these patients were all suffering from rhabdomyolysis (disintegration or dissolution of muscle) and myoglobinuria (myoglobin, a muscle pigment, in the urine). It was the myoglobin that caused the urine to be coffee-colored.

Describing the mechanism by which this deterioration takes place, the Dallas kidney specialists say it starts when the toxicity of the injected drug, combined with what is called "pyrogen reaction" (the reaction that occurs when a foreign substance enters the blood stream) leads to fever and fasciculations (rapid local contraction of muscles).



Doctors have discovered a serious syndrome in people who inject amphetamines.

At the same time, as the person begins to sweat, vomit, and have diarrhea, he loses fluid and his blood volume goes down. His blood supply becomes inadequate — the condition known as ischemia.

The combination of fever, intense muscle activity, and ischemia, causes muscle necrosis. Dr Knochel, professor of internal medicine at University of Texas Southwestern Medical School, explains it this way: "The amphetamine causes a tremendous contraction and relaxation of skeletal muscle. When you drive muscle that hard — to the point of fatigue and beyond — for some reason the cells become leaky. Myoglobin and other cellular contents leak out and, in due course, you have muscle necrosis."

The myoglobin that escapes from muscle cells when they disintegrate, aided by the intravascular coagulation, can destroy the kidney. Potassium, released into the blood stream at the same time, can stop the heart, Dr Knochel adds.

The Dallas physicians were able to save the lives of all five of the patients on whom they reported. But three of them had significant permanent kidney damage.

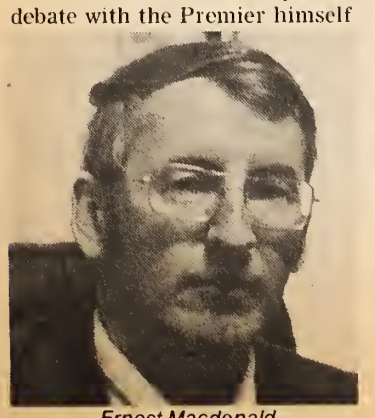
PEI votes down bill to raise legal drinking age

By Karin Pargas

CHARLOTTETOWN, PEI — The drinking age in Prince Edward Island will remain at 18, despite vehement protest by some of the province's citizens' groups.

In a free vote in mid-May, members of the PEI Legislative Assembly voted down a bill to raise the legal drinking age to 19. The bill was defeated by a 14-to-8 margin with 10 MLAs absent during the vote count.

The bill — originally introduced into the Assembly by Liberal Premier Alex Campbell — followed months of public debate with the Premier himself voting against it in the end. The Premier said it would be inconsistent of the government to prohibit 18-year-olds from drinking when they are considered adults in virtually every other aspect.



Ernest Macdonald

The Addiction Foundation of PEI, a Crown corporation, supported the bill. But, according to its executive director, Ernest Macdonald, there was general agreement on the island that raising the age would have only been a partial solution to the problem of teenage drinking.

The defeat of the bill, however, does not necessarily mean the end of discussion.

"The issue will certainly come up again because many groups like the Women's Institute and the Catholic Women's League support it," Mr Macdonald told **The Journal**. "Our foundation didn't feel raising the age would stop the problem, but it would have at least kept high school students away from liquor."

The drinking age in this Maritime province of Canada was lowered in 1972 to 18 years of age from 21.

A survey conducted by a private agency on the island — The Alcohol and Drug Problems Institute — showed one of five students in grade seven were using alcohol at least occasionally. This had risen drastically by grade nine, when 50% of the students were drinking. By grade 12, three-quarters of the students drank which, the survey points out, almost parallels the drinking habits of the adult population of PEI.

Other statistics excerpted from the survey were:

- Students from more affluent families were more likely drinkers than those from lower socio-economic groups.
- Those who attended church regularly showed a lower incidence of alcohol use than those who did not.
- School performance was a major factor — students with average marks above 75% had a 39% incidence of alcohol use, those with averages from 50% to 75% had a 63.1% incidence of alcohol use, and those below passing grades had a 58.8% incidence of alcohol use.
- Females showed a lesser incidence of regular drinking than males.

Since a similar study was made in 1972, the time when the drinking age was lowered from 21, alcohol use by island students had increased 20%.

MSU's 25% rule showing results

LANSING, Mich — A new approach to curbing drinking among college students at Michigan State University has yielded promising results in the past three years.

Dubbed the "25% rule," it says 25% of the beverages served at campus parties must be non-alcoholic.

The 25% rule is one part of a comprehensive program that has made the university a leader in handling student drinking in a sensible fashion.

Although campus police rate alcohol a greater problem than drugs at the university, Michigan State has no greater student alcohol problem than other campuses.

Between 85% and 90% of all the students drink occasionally, according to estimates.

And of all drinkers, some of whom may take only one drink a month, about 10% could be considered problem drinkers.

In January 1972, a Michigan law lowered the age of majority to 18 years from 21 making it legal for anyone over 18 to purchase liquor.

At that time, the university established a program to teach students to drink responsibily.

Some of its features:

- Travelling teams of recovering alcoholics, frequently members of Alcoholics Anonymous, go from floor to floor in residence halls and talk to students.
- Students are provided with information on drinking and alcohol from certain state and national agencies.
- The education program does not condemn drinking but removes it as a central reason for throwing a party or getting together.
- Residence hall staff are educated so they can spot people having problems with alcohol.

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Letters to the Editor

Is fear effective?

Long an admirer of Yardley Jones' draughtsmanship and wit . . . wish I had a fraction of each . . . his April 1st cartoon is a bit of a disappointment.

By any criteria — "drug of choice", route of administration, or consequences — the message of needles and death seems to be a departure from the mainline (oops!) messages identified with the Addiction Research Foundation.

Or has something changed?

Are liminal messages of fear and anxiety seen to be more effective ways to increase awareness and understanding? Perhaps some of our behavioral scientists could comment on this.

Lawrie Purdy,
Communications Officer
The United Church of Canada
Hamilton, Ontario

Let's hear it for BC

I was fascinated to read in **The Journal** (June 1) 'Under the surface of the world next door', by Karin Pargas on Newfoundland.

We in the west read so little about the eastern provinces of Canada.

Now what about the rest of the country? In recent months **The Journal** has covered the Northwest Territories and Newfoundland and I welcome these articles. Let's hear about some other parts of Canada — the Yukon, Quebec, and not least, British Columbia, my home.

Gerald Doner
Nanaimo
British Columbia

A thank you

I find **The Journal** a very useful publication for course information pertaining to drugs and also enjoy the list of publications and other materials for drug abuse education (New Books).

Harry H. Hoitsma, chairman
Department of Health Professions
Montclair State College
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'Not today madam, I have a headache.'

Inside Science

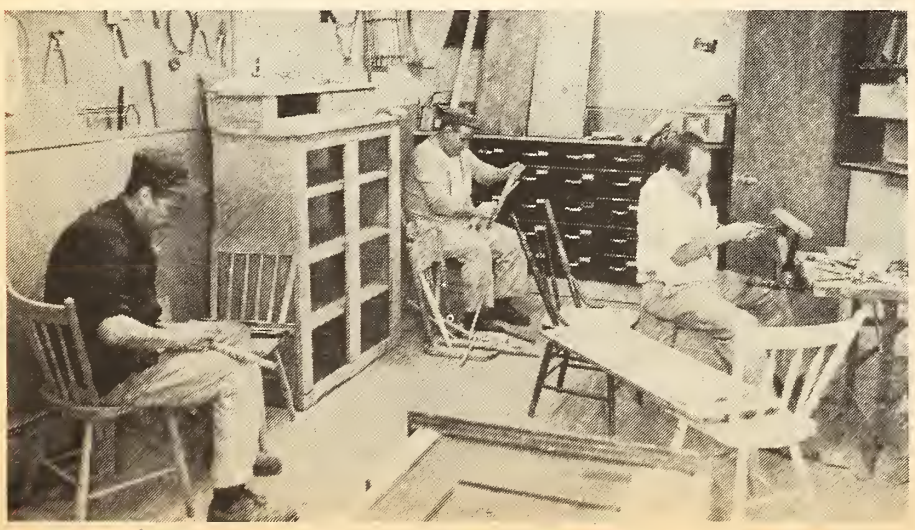
Bon Accord - a program in

By Gail Clare

WITHIN THE next few months it is likely that the Addiction Research Foundation's Bon Accord rehabilitation program will be transferred to some other agency. This is in line with ARF's commitment to providing direct services, only if these services have a major research component.

Bon Accord has had such a component for several years but it recently became clear there were limitations to the extent that research and service provision could be combined within the Bon Accord program. Because of the structured nature of the program and its commitment to providing meaningful, paid work to its residents, there are limits to the extent to which the program can be changed for research purposes.

The decision to transfer Bon Accord to another agency, however, comes after a lengthy period of experimentation, the outcome of which has been the development of a good, basic program which includes most of the elements that one would reasonably expect in a program for skid row men. The latter stages of such experimentation were concerned with the development and evaluation of a system of behavior review groups designed to increase staff/resident communication and to help residents to formulate plans for behavior change and to monitor resident progress.



ARF's rehabilitation program for skid row men will be transferred to some other agency.

On entering Bon Accord, residents are assigned to one of three or four groups which meet weekly under the direction of a staff member. At each meeting, all group members are expected to report on their accomplishments during the previous week and to set objectives for the coming week.

Problems in implementing previously agreed objectives are discussed and future plans revised accordingly. Group members are encouraged to help each other in the achievement of goals and to make suggestions as to goal selection.

The progress of individual residents is assessed partly in terms of the achievement of personal goals and partly in terms of the meeting of objectives set by the program. Bon Accord has a phased system of expectations and individuals' progress toward these expectations is monitored by the behavior review groups. Demands placed upon new arrivals are less exacting than those placed on more senior residents who are expected to set more long term goals and to be more concerned with re-integration into society.

The group always focus on specific behaviors and this focus seems particularly suited to the kind of skid row men Bon Accord tends to attract. Thus, the behavior of "buying a shirt" is a readily manageable element en route to the goal of improving personal appearance and both staff and residents can see that a resident's success or failure in his commitment to shirt buying is a valid index of progress toward this goal. Similarly, the behavior of writing a letter to a prospective employer is a necessary and manageable step towards employment.

The behavior review groups have then been useful in helping staff and men to define progressive steps towards agreed upon goals and they provide a forum for the regular review of progress in very specific terms.

The groups have not, however, solved all problems. Rather, they have tended to highlight the problems that are well known to those who work with skid row men.

Some men are barely literate and thus cannot make use of the running record of progress provided by their individual work books. Some are reluctant to make any commitments. Some have major difficulties completing the simplest tasks and sometimes these difficulties reflect very severe personal problems. The lack of interpersonal skills and interest

Backgrounder

Consumption curve controversy cools down

By John Shaughnessy

TORONTO — The use of overall consumption levels as an index of alcohol-related problems in a society and as base for preventive measures has been challenged by United States investigators.

But Canadian supporters of the theory, while remarking on the sophistication of the US study, suggest it contains a major flaw.

In their 37-page critique of "The distribution of consumption model of prevention", Douglas A.Parker, PhD, and Marsha S. Harman, Phd, argue that the empirical evidence for the statistical properties (in the model) is inadequate, that the conceptual range of independent and dependent variables is overly circumscribed, and that an alternative model which incorporates more variables and relationships is needed.

Wolfgang Schmidt, a supporter of the model, told **The Journal** the American critique is very sophisticated and the best he has seen so far. But in his view the authors made a major mistake in seeing this approach as an all inclusive one. "In itself, the model is not the answer but it provides the conditions and circumstances to enable other preventive measures to succeed."

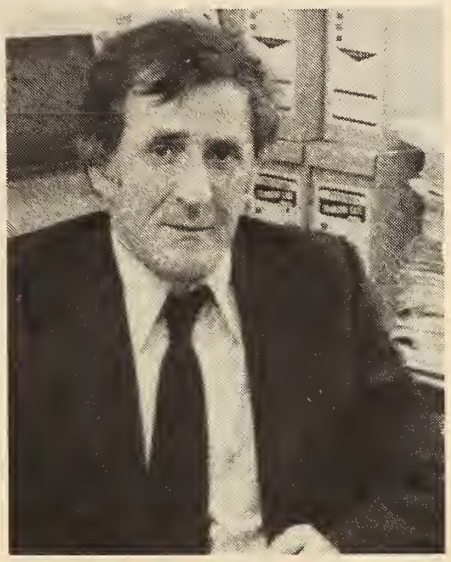
Further, he says although many of the criticisms made by the US investigators have merit, they do not invalidate the basic propositions relevant to prevention in the mode.

These are that a change in the average consumption of alcohol in a population is likely to be accompanied by a change in the same direction in the proportion of heavy consumers, that since heavy use of alcohol generally increases the probability of physical and social damage, the average consumption should be closely related to the prevalence of such damage in any population; and that any measures, such as those regulating the availability of alcohol which may be expected to affect overall consumption, are likely also to affect the prevalence of alcohol problems, and hence should be a central consideration in any program of prevention.

The work of Ledermann has been used as the foundation for the distribution of consumption model. Drs Parker and Harman, from the National Institute on Alcohol Abuse and Alcoholism and California State University at Long Beach, find serious flaws in his work and the use to which it has been put by subsequent researchers.

For example, they say that the samples used by Ledermann leave much to be desired methodologically; that he sets maximum consumption (365 liters) too high; and that differences in the distribution of consumption within populations has been either ignored or stated to be of no consequence.

Dr Schmidt, director of Social Studies, and Robert Popham, head of research planning, at the Addiction Research Foundation of Ontario, admit some fault can be found with Ledermann's work on the distribution model. "It is clear that there are deficiencies, especially in his derivation of so-called constants."



Wolfgang Schmidt

But despite these shortcomings, Dr Schmidt says the central element in Ledermann's concept has not been seriously threatened by the technical flaws and mathematical niceties on which the American critics and others have focused.

"In fact, the evidence accumulated since Ledermann's 1956 report has greatly strengthened the main proposition; the mean and rate of heavy use are closely related."

With regard to the "constants", Drs Parker and Harman maintain that the distribution model can only provide an approximation and that neither the dispersion nor the number of heavy consumers in a population can be uniquely determined by the mean consumption. Dr Schmidt agrees.

He counters, however, that for most practical purposes, a simple "one-parametric distribution" (such as the Ledermann distribution) is likely to give a fairly good approximation.

"It is regrettable that Parker and Harman have been preoccupied with the shortcomings of the Ledermann equation as a device to obtain specific estimates of prevalence. Certainly the variations in dispersion will increase the range of error of such estimates. The point is simply that this error is not sufficiently large to seriously threaten the central proposition of the model that average consumption and heavy consumption covary."

In their final assessment Drs Parker and Harman claim that since the relation between mean and measure of dispersion is not constant, and since the distribution is not necessarily "lognormal", the Ledermann proposition is not redeemable.

In Dr Schmidt's view, constancy in dispersion or in the relationship between mean and dispersion is not a prerequisite. What is required is an absence of major variation in the measure of dispersion among populations, and "there is a wealth of evidence which indicates that this condition has been met.

"The crucial point is that the distribution is approximately one-parametric, and on this issue, there exists a great deal of supportive evidence from a large number of populations. Thus, the Ledermann proposition is not only redeemable, but is in our view, quite indisputable."

Drs Parker and Harman also challenge the model's emphasis on cirrhosis mortality as an indicator of alcohol problems. They feel that in addition to knowing the effect of a change in consumption on the cirrhosis mortality, the effects on other health and social problems should be determined in the design and evaluation of any prevention program.

"In addition to knowing the effect of a price raise and consumption change on the cirrhosis rate, we would also like to determine the effects on the rates for hypertension, cancer, mental illness, traffic accidents, child abuse, and other problems."

They also raise the question whether reducing per capita consumption through price control might only result in a change in drinking patterns from steady to episodic consumption, from greater frequency and total consumption, to greater quantity consumed per occasion. "We are asking if a set of policies which might reduce a chronic problem such as cirrhosis, might not increase an acute problem such as cognitive functioning."

The American critics contend certain alcohol-related problems appear to be associated with a particular drinking pattern and with certain socio-economic groupings. Because of this they say it would seem that it is necessary to introduce further variables in addition to per capita consumption into a predictive model of alcohol related problems.

In defense of the use of cirrhosis mortality as an indicator of alcohol problems, Dr Schmidt emphasizes the cirrhosis death rate is employed because of its particular value as an indicator of heavy consumption, and not because it is by any means the only important consequence of heavy drinking.

"An increase in deaths from cirrhosis in a given year implies that, at some previous time, the number of chronic heavy users of alcohol increased proportionately. Since consumption patterns that are conducive to the development of cirrhosis also result in a wide range of other health and socio-economic problems, it is a reasonable assumption that changes in cirrhosis mortality reflect changes in all those problems resulting from chronic heavy use of alcohol.

Dr Schmidt also disagrees with the American critics' concept of the role of drinking patterns. He says it is the volume of alcohol consumed over the drinking life, rather than the pattern of consumption which determines the risk of cirrhosis. It just happens that steady drinkers tend to consume more in the long run.

'Evidence accumulated since Ledermann's report has strengthened the main proposition; the mean and rate of heavy alcohol use are closely related.'

In their critique, Drs Parker and Harman suggest that in some cases alcohol may prevent the development of some diseases. Dr Schmidt disagrees. "We do not share Parker and Harman's belief that increases either in individual or in population consumption levels — no matter how they are brought about — may involve compensatory beneficial effects. Nor do we share their concern that decreases are likely to produce a significant rise in the prevalence of new problems through a shift towards more destructive patterns of use. There is simply no evidence to support such predictions."

The critics and supporters of the distribution model also disagree about the validity of the "availability proposition" — that per capita consumption can be reduced by raising the price of alcoholic beverages relative to disposable income.

Drs Parker and Harman suggest this proposition is applicable only to upper segments of the middle class. They refer to a study showing that the poor often rely on alcohol as a stress management device, and note that the less the disposable income left free by alternatives, the greater might be the consumption of alcohol.

Dr Schmidt argues that the greater the disposable resources left free by alternatives, the greater the consumption. He suggests the American critics erred by using a global proposition to explain differences between socio-economic subgroupings within the same population. He also asks: "If low income families have high rates of anxiety which cause high rates of alcohol use and attendant problems, can we not assume that the amount of this reliance will be greater where alcohol is inexpensive, readily available, and where attitudes towards drinking are permissive?"

The potential value of manipulating price to control the economic accessibility of alcoholic beverages and the level of consumption in a population is challenged by Drs Parker and Harman on three grounds: that the price of alcohol may be of little significance for heavy drinkers; that the price of one or another class of alcoholic beverages may be of little significance; and that the influence of income has been given insufficient attention by the proponents of price control.

In reply to the first point, Dr Schmidt said "even assuming persons labelled alcoholic are unable to control their drinking and would therefore be unaffected by changes in price, is not the principal aim of a preventive measure to affect incidence rather than prevalence?

"Since the death rate of alcoholics greatly exceeds that of the general population, natural attrition alone would rapidly diminish prevalence if the inflow of new cases could be reduced. It is here that price control might be expected to have its most significant effect."

On the issue of beverage class differences, Dr Schmidt points out that major class beverages may serve as substitutes for one another, and "cross-elasticities" have to be taken into account in the formulation of price policies.

For example, an increase in the price of spirits may lead to an increase in demand for beer. "It is quite clear that recommenations as to how price policies should be formulated cannot be at once specific and universally acceptable."

Dr Schmidt concedes Drs Parker and Harman's point that income is a very important determinant of demand for alcohol. However, he suggests price manipulation may counteract the effects of increasing affluence. "Under conditions of rising income, price increases may not produce a reduction but may limit the income-induced rise in demand."

Overall it appears that Drs Parker and Harman reject the distribution model as a base for preventive measures because it is too simplistic.

"In introducing a prevention program we need to know the values of a number of variables, not just availability but also heterogeneity, not just how availability affects per capita consumption but also how it bears upon drinking patterns, not just how drinking patterns relate to medical problems but also how they relate to social problems. At the point that we can assess these changes, we may be ready for massive social engineering."

On the other hand, Dr Schmidt's defence of the single distribution model stems from the historical context in which it first appeared. In the 1950s, many people saw the drinking habits in countries such as France as preferrable to those in countries where drunkenness was common. The conclusion was often that a permissive approach to alcohol leads to fewer problems.

'In introducing a prevention program we need to know the values of a number of variables, not just availability, but also heterogeneity.'

Studies however have shown that there was a rapid rise in alcohol consumption which was occurring during this period and has continued since. "Trends in liver cirrhosis mortality made at least one point abundantly clear," said Dr Schmidt. "The overall level of consumption as a reflection of the size of the alcohol-related health bill in a population could not be ignored as a focus of preventive effort." Price control was suggested as a possible method of prevention.

Dr Schmidt conceded that in some of their work, he and his co-workers could be justly accused of some overstatement and over simplification. "To a degree this was due to a deliberate strategy to secure a hearing for a point of view which ran counter to the prevailing sentiment. In retrospect, we now doubt the effectiveness of such a strategy, and are inclined to take a more conservative approach."

transition

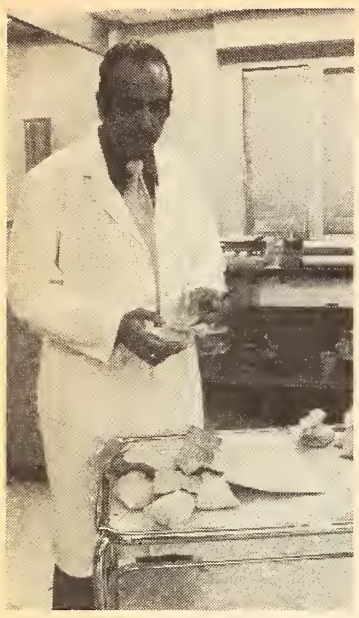
among skid row men is particularly apparent in the groups.

Put simply, many men are not very "groupy" and often the groups are like a series of publicly conducted individual sessions with each man impatiently waiting his turn. Men are not readily inclined to help each other and insofar as any group processes operate, these tend to be counter-therapeutic in that men do not want to be seen as "grassers", "sneaks", or "staff pets."

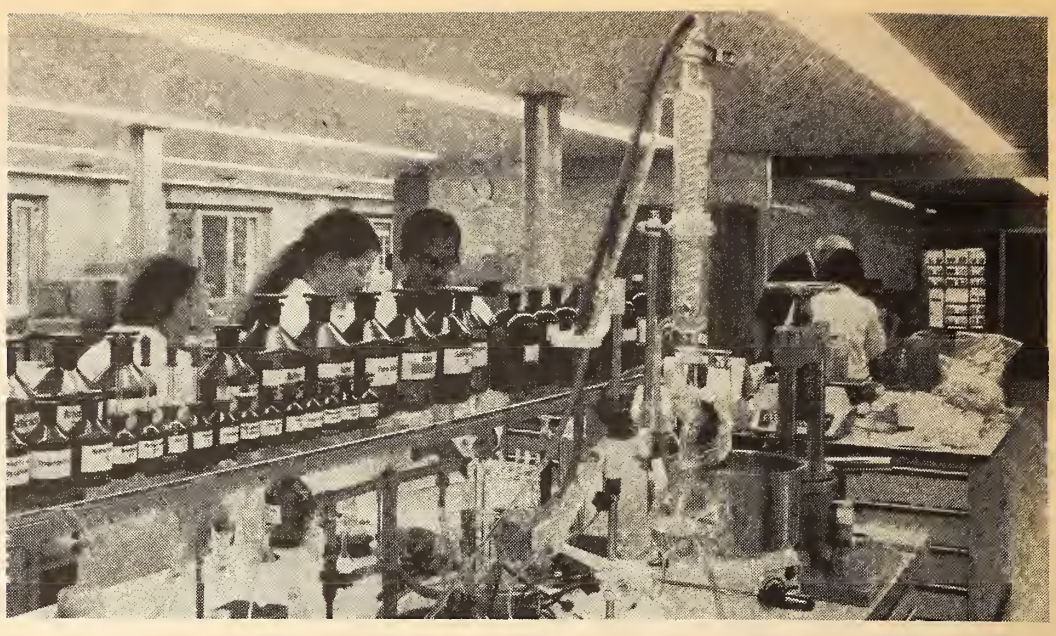
A major problem is, of course, time. The severity of the problems of many skid row men makes expectations of their rehabilitation quite unrealistic without major interventions. The irony is that those who need most help often get the least because they are the most difficult to reach and most frustrating to work with — an irony which, incidentally, characterizes the whole of the alcoholism treatment.

The Behavior Review System has been in operation for almost one year and the progress of 80 residents has been monitored. Follow-up of these residents is about to begin and their progress will be compared with that of a former series of Bon Accord residents and with matched samples of men who have been residents of Ontario halfway houses.

(Ms Clare is a senior research assistant with the Addiction Research Foundation of Ontario.)



The search for a super poppy . . . Vishnu Mathur inspects bags of opium poppy seeds from villages in India (left).



A general view of the United Nations Narcotics Laboratory, Palais des Nations, Geneva (right).

Story and photos by Jim Magee

Changing patterns of drug abuse are reflected

UN narcotics lab works across broad spectrum

GENEVA — The neat little jute bags come into Geneva's Cointrin airport from dispatch points all over India. Watched over as closely as if they were bags of gold, they are routed to one of the world's most international research centres — the United Nations Narcotics Laboratory on the top floor of the Palais des Nations.

Each bag, carefully labeled with the village of origin, contains *Papaver somniferum* seeds. They form part of a world search, coordinated by UN scientists, for a bigger and better opium poppy.

Set up in 1948, the Geneva centre has grown steadily in importance, and its research and training program has developed across a broad spectrum, reflecting the complex and changing patterns of drug abuse.

Under the direction of Norwegian-born Dr Olav J Braenden, the laboratory staff, working with scientists in many other countries, are evaluating the possibilities of "boosting" the alkaloid content in the opium poppy.

As part of the climatic research, poppies are being grown in countries stretching from the Mediterranean to the Arctic Circle. The flow of reports, in some 15 languages, covers such questions as soil alkalinity and acidity, seed yield, resistance to cold and heat, and methods of harvesting.

Another branch of the program at the laboratory is concerned with research into the scarlet poppy, *Papaver bracteatum*. A big attraction, of course, is the fact that thebaine, from which codeine can also be derived, is obtained from the scarlet poppy without production of opium.

Efforts are therefore being devoted to improving the thebaine yield of the scarlet poppy. One disadvantage in the process is that thebaine can be converted not only into codeine, but also into a wide range of narcotic analogs known as the Bentley compounds.

One of these is etorphine, which has been shown to induce a morphine-type euphoria and physical dependence in man. However, its high potency and short action make it less likely to be subject to abuse, in the opinion of international experts who met recently in Geneva to study the question.

The scientists at the UN laboratory do not spend all their time in their ivory tower, with its view over Lake Geneva. Not long ago some members of the team turned up in the bazaars of villages in East Africa, where they spent some time quietly buying samples of khat.

Now under study both at the National Institutes of Health in the United States and also in Geneva, khat consists of the fresh leaves from a tree that grows mainly in East Africa. The leaves are chewed by the user.

Khat is not yet under international control, although the question has been under debate for a number of years. One major problem is how to classify it: in an attempt to settle that issue, khat is now undergoing a great deal of scientific analysis. So far, more than 10 active substances have been isolated, whose chemical structures are being closely examined.

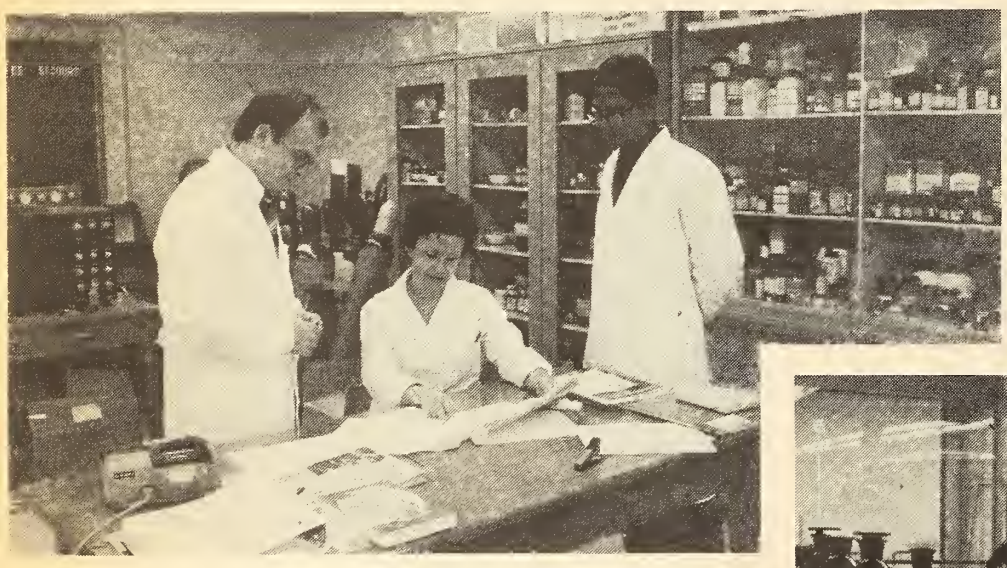
Another important area of research concerns cannabis. It is generally recognized that there is a need for much more scientific data on cannabis, and research is going on concerning the botany, taxonomy, and other aspects of the plant, its chemistry, the substances in cannabis smoke, and the variations in potency of cannabis resin in different climates.

As part of the work, the UN laboratory provides reference samples of cannabis for researchers elsewhere.

The laboratory is also winning increasing recognition as a centre of excellence, and with the help of subsidies from the UN Fund for Drug Abuse Control, there are regular training fellowships for personnel from the developing countries.

Apart from the reference libary — there are 40,000 references on drugs of abuse and computerization is being planned — trainees are introduced to the latest equipment and techniques of drug detection and analysis.

Present staff at the laboratory includes nationals of the US, Japan, Norway, South Africa, the United Kingdom, Lebanon, Laos, and Switzerland. Currently on fellowships are trainees from India, Pakistan, the West Indies, Thailand, Iran, and Turkey.



Studying a printout, from left are Gurken Ak, Turkey, staff pharmacist Mona Saghir, Lebanon, and A. R. Khan, Pakistan.

Photo above: At the microscope, Vishnu Mathur who is on the staff of the Indian government's narcotics divisions, is studying modern instrumentation at the UN laboratory.

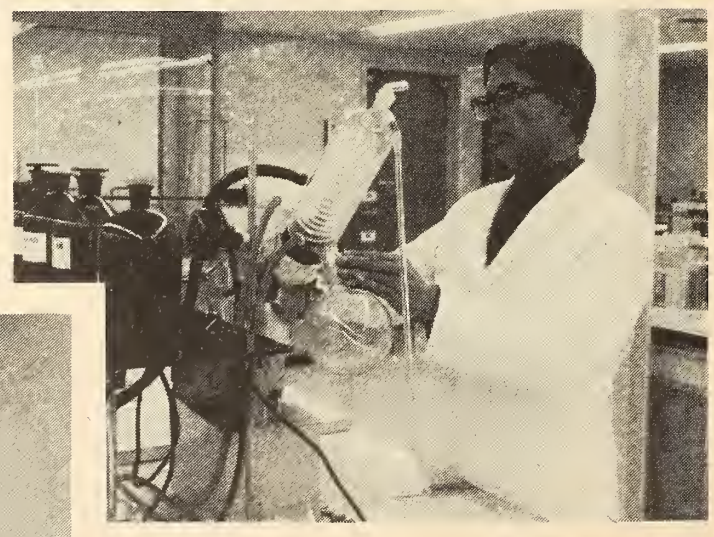


Photo above: At work in the laboratory A. R. Khan of Pakistan.

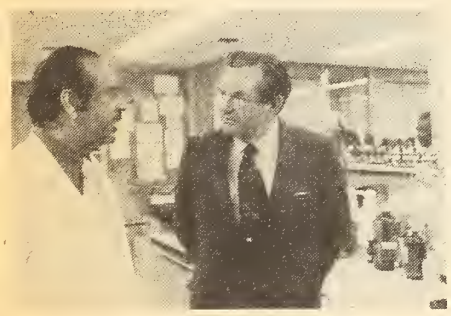
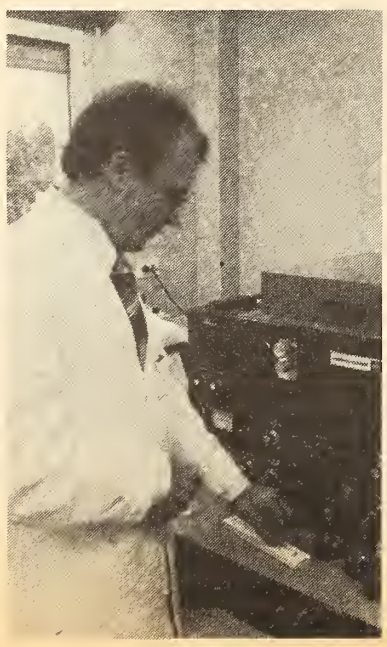
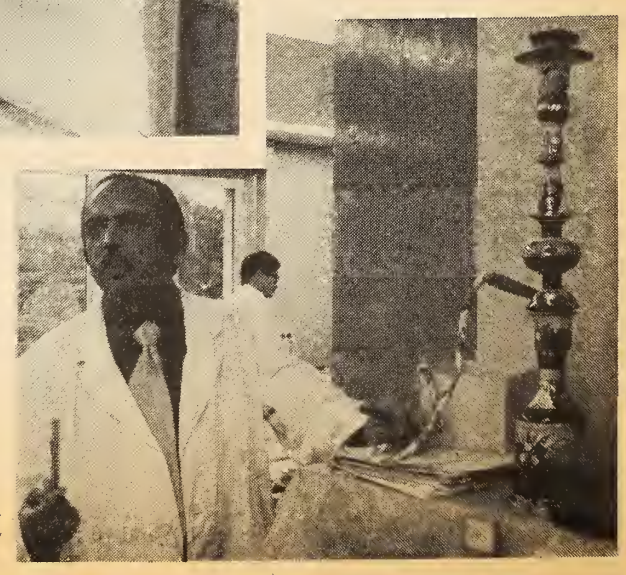


Photo above: Dr Olav J. Braenden of Norway, director of the UN Narcotics Laboratory, (right), discusses a problem with Vishnu Mathur of India.



Gurken Ak of Turkey is acquiring skill in the use of gas liquid chromatography (right).



Instrumentation of another kind. Vishnu Mathur with the lab mascot — a finely ornamented water pipe (right).

Royal College delivers a third blow to smokers

By Alan Massam

LONDON — The Royal College of Physicians of London — one of Britain's most authoritative medical voices — has once again called for tough measures to curb "the unacceptable health hazard" of smoking.

In a report *Smoking or Health* it says ALL advertising of high and medium tar cigarettes should be banned immediately and the advertising of low tar brands phased out over a period of years. At the moment cigarette ads are banned only from television.

The college also wants to see manufacturers urged to withdraw high and medium tar brands from the market so that about 80% of Britain's smokers would be obliged to smoke the milder type (about 20% already smoke mild cigarettes).

The college bases its medical proposals on the claim that most smokers are quite willing to smoke milder cigarettes if persuaded to do so and that they do not (as was previously thought) merely increase the number of cigarettes smoked to make up their nicotine intake.

Smoking or Health is the Royal College of Physicians' third report on the perils of the weed in 15 years. The first two: *Smoking and Health* and *Smoking and Health Now* had a measurable impact on smokers.

But the college is far from happy with the degree to which Britons have turned their back on tobacco and charge that government steps to deal with the problem have been "paltry and hesitating."

It calculates that on average a smoker shortens his or her life by 5½ minutes with every cigarette smoked — not much less than the time spent actually smoking it. Statistics to puff upon:

- The college claims that between 2½ and 4 out of every 10 smokers will die because of their smoking and stress that besides shortening life the habit causes prolonged ill health;
- up to 50 million working days per year in the UK may be lost as a consequence of cigarette smoking;
- smokers of over 20 a day take twice as much time off work as non-smokers.

The report also emphasizes the importance of preventing young people from taking up smoking. It says that some children start the habit at age 5 and one third of adult smokers began before they were 9.

A Briton gulping down some 'energy'.

English get 5.2% of energy from their trips to the pub

LONDON — Alcohol consumption in Britain has risen by about a third in the last 10 years to 1974 and an Englishman gets an average 5.2% of his energy from alcohol. But this is still considerably less than the consumption of the average Frenchman who gets 8% of his energy from alcohol.

These estimations have been published by the British Nutrition Foundation in a paper *Nutritional Implications of Alcoholism* by Leena Pekkanen and Olof Forsander. The authors say as alcohol consumption continues to rise in most Western countries, alcoholic drinks are becoming an important element in the diet.

They stress that obesity is a particular problem of the moderate drinker, but the chronic misuser of alcohol often suffers from malnutrition in various forms.

Chronic consumption of alcohol, they say, may diminish appetite by depressing the hypothalmic centres which regulate food intake. The most common deficiencies of the alcohol abuser are the water soluble vitamins which can cause particular forms of anaemia, malabsorption, and beri beri.

"An alcoholic suffering from malnutrition is in a vicious circle," the authors add. "The state of malnutrition accompanying chronic consumption of alcohol leads to impaired absorption of nutrients and thereby accentuates nutritional deficiencies."

They conclude that nutritional therapy is an essential part of the treatment of alcoholism. Extra intake of nutrients is needed to restore energy depletion and to repair tissue injury while regular meals are part of "social recovery."

15- to 24-year-olds heavily over-represented

NZ has biggest crop of young drinking drivers

WELLINGTON, NZ — Drivers in the 15 to 24 age group are heavily over-represented in alcohol-related accidents in New Zealand, probably more so than in any other country.

A 17-year-old is five times more likely to be involved in an alcohol-related accident than a 24-year-old, according to a Ministry of Transport analysis.

It is not known, however, whether people aged 15 to 24 drive after drinking more often than older people, Wayne A. Perkins told the Summer School on Alcohol Studies.

"It is also true that our knowledge of the reasons that make young drinking drivers so vulnerable to this type of accident is very small," said Mr Perkins, of the ministry's traffic research section.

People under age 20 are responsible for nearly three out of 10 reported alcohol-related accidents causing injury in New Zealand — roughly double the proportion in Ontario or Great Britain.

As the minimum legal drinking age is 20 in New Zealand and 18 in Ontario and Britain, the result at first appears rather surprising, Mr Perkins said. But in New Zealand the legal drinking age seems to have little to do with access to alcohol, and young people have more access to motor vehicles than do their counterparts in other countries (55% of licensed drivers aged 15 to 19 have their own vehicles).

A household survey on the drinking and driving behavior of 750 persons aged 15 to 24 revealed 294 (39%) had driven within three hours of driving at least once in the previous week, Mr Perkins said.

From the amount and type of alcohol consumed on a randomly selected occasion, more than 20% of this group apparently exceeded the legal blood alcohol limit of 0.1%. Nearly 50% drove within 15 minutes of finishing drinking.

Reasons for going to the place where drinking took place (32% said "friends were going") suggested most young New Zealanders do not see positive alternatives to alcohol-related activities or watching television, said Mr Perkins.

In 40% of cases, the drinking occasion had been arranged less than six hours ahead. The heaviest consumption occurred among the 34% who had planned their drinking three days or more in advance.

Medical undergrads need alcohol course

LONDON — Undergraduates at medical schools should have special education in the problems of alcohol, a leading British authority believes.

Max Glatt, consultant psychiatrist at the St Bernard's and University College Hospitals, London, makes this proposal in the *Journal of Alcoholism* (Vol II No. 3).

He says doctors are clearly in the forefront of those who should be a target for specific education as a 'high risk' group. If the problems of excessive drinking were included in medical school curricula, there would be a number of "beneficial consequences."

Medical students would become aware that in their future professional life they might be exposed to a combination of the two prime factors often leading to alcoholism: the temptation of "relief drinking" and the "acceptance" of drink by those around them.

"They would thus be more on the lookout for early warning signs in themselves . . . and in their patients," Dr Glatt says.

"A doctor aware of the risks and knowledgeable of the condition would be less likely to become a casualty himself, but he would also be in a position to suspect the development of alcoholism early on in his patient's drinking career, and to arrive at an earlier diagnosis.

"It is well known that a doctor, once he has 'spotted' one or two alcoholic patients, begins to detect more and more among his patients."

Dr Glatt says as the lay public tends to take a cue from doctors in its attitude to alcoholism, a general acceptance by the profession that alcoholics are sufferers from illness and deserving of help would go a long way towards removing the stigma still militating against early diagnosis.

Around the World

Families affected

Four to five million West Germans are estimated to be directly affected by drug and alcohol abuse because they are close to family members of addicts and alcoholics. The figure, according to West Germany's Federal Agency Against Addiction, represents from 7% to 8% of the country's total population. The agency has revised upwards its estimates of the number of alcoholics in West Germany from one to 1.5 million, of which 20% are women and 10% are under age 24.

Fines to go up?

Fines for under-age drinking may be increased by the British Home Office. Present penalties are under review, and it is likely that the maximum fine for buying or attempting to buy alcohol while under age will be raised to £100 from the current £25.

Scotch exports

Scotch whisky exports from Britain to Lebanon dropped by 88% in the first half of 1976. Lebanon took 391,996 proof gallons of Scotch in 1974, but that had dropped to 18,706 proof gallons between January and June, 1976. Meanwhile, exports to Cyprus went up by 305%, to 99,810 gallons in early 1976, and Syria also increased its import of Scotch by 109%. Scotch exports to Israel rose by 30.75% to 103,511 proof gallons, and Egypt took 12.69% more Scotch, or 151,743 proof gallons.

Vatican's charms

The number of security staff in the Vatican museum has been increased in order to watch for visitors high on drugs. Many people seem to find that being surrounded by art treasures is a pleasant situation for drug taking, according to the Vatican museum controller, Walter Persegati. "Every year we escort hundreds of suspect persons out of the museum, especially in the summer when the crowd is mixed, we often find people who are visibly hallucinating." The Vatican saw drug takers as "potential vandals" and so has been forced to increase the number of security guards.

Drive fails

Despite the Iranian government's campaign against drug smuggling, traffic remains heavy. A total of 18,500 narcotics peddlers were arrested in the year ending last March, officials report. Antinarcotics squads seized 300 pounds of heroin and more than 4,557 pounds of opium during the year. Under Iranian law anyone caught with more than 2.2 pounds of opium or more than a third of an ounce of heroin is subject to trial by a military court and faces execution by firing squad.

Five pence

A five pence levy on every pack of cigarettes would help offset the cost of treating diseases caused by smoking, Action on Smoking and Health has told the British Royal Commission on the National Health Service. The levy would put up the cost of smoking by 10% and raise £350 million, ASH claims.

Drinkers get blacklisted in Falklands

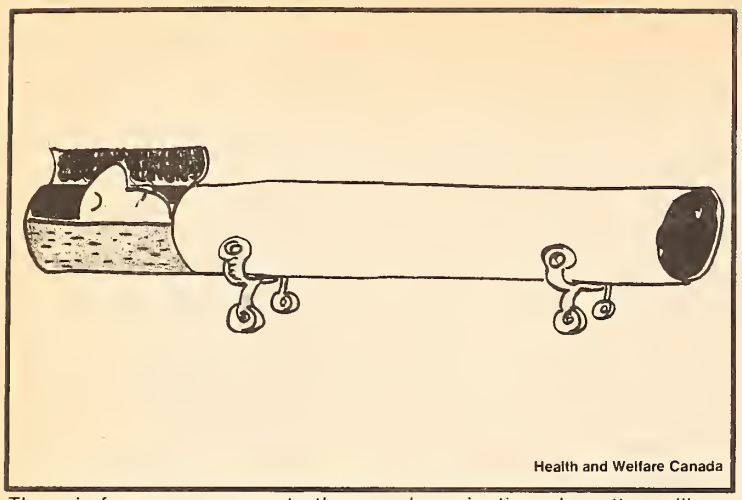
PORT STANLEY, Falkland Islands — Drink too much in this remote British Colony in the bleak South Atlantic, and you run the grave risk of being put on a blacklist.

That means no shop or bar will serve you an alcoholic drink.

And, strictly speaking, your friends should not even offer you a glass of anything stronger than orange juice in the privacy of their homes.

Police here say drink is at the root of what little crime there is in this colony where 1,900 people live on the 200 islands of the Falklands Archipelago.

Nevertheless, Falklands Police Chief Inspector Terry Peck does not rate drunkenness on its own as a serious problem.



Health and Welfare Canada

There is fear among experts the new low-nicotine cigarettes will encourage smokers to puff more — and ignore the fact they are still inhaling the many other chemicals still present in the tobacco.

Risks in low-tar smokes?

By Jean McCann

SAN ANTONIO — People who smoke the new low-tar, low-gas, low-nicotine cigarettes may be smoking their way into more trouble than if they had stuck to the old-fashioned "high everything" cigarettes.

This is the thinking of some researchers involved in a giant study of the causes of atherosclerosis, which includes the relationship between smoking and the development of plaques and narrowing of arterial walls.

"What we're concerned about is the number of cigarettes smoked", said Henry C. McGill, Jr., University of San Antonio pathologist who heads a consortium running the Specialized Center for Research in Arteriosclerosis which has just received a new $4.9 million grant.

"There is the fear that with less nicotine in the new cigarettes being marketed, people may smoke more of them. The addicted will then be getting even more of the 2,999 other chemicals in cigarettes, some of which may be worse than the nicotine."

Dr McGill said that as a part of the new research grant, the effects of smoking different types of cigarettes will be studied. At present, 18 baboons trained at the Southwest Research Foundation to smoke, are getting a cigarette which is specially-made to be a kind of "average American cigarette of the last several years."

"These animals are being compared with 18 other animals, who are smoking a sham cigarette, and they're all subjected to the same diet and training, and so forth. So far, we see no changes in lung function in the smokers, but then we didn't expect to see this after only one year."

Dr McGill said the animals will probably be sacrificed at about five years of age, to determine what effects smoking has had on atherosclerosis.

"We know from studies on humans that cigarette smoking irritates the plaque in the arterial wall. It seems also that smoking does something to the acute coronary episode, perhaps by affecting the clotting mechanism, or the electrical system of the heart, which also contributes to the terminal episode of the heart attack.

"The same mechanisms should be involved with the baboon."

Dr McGill said beyond the two major hypotheses about how smoking may affect the development of fatty, narrowed artery walls, and heart attacks, there are also a number of others. One is that the carbon monoxide seen in the blood of smokers may be responsible for cardiovascular problems. "But there are only about 3,000 substances that have been identified in cigarette smoke, and it could be any one of these."

One measurement being done on the animals is of their carbon monoxide levels, he said. A metabolite of nicotine in the urine is also being monitored to check nicotine absorption. Heavy metals that accumulate in the body from smoking are also being measured.

As for the role of nicotine, Dr McGill believes it is the major addictive substance, and that it may or may not cause atherosclerosis, but certainly aggravates it.

"It certainly can raise blood pressure transiently, and cause an increase in platelets, and it also increases the heart rate. So it could be a factor in the terminal episode."

Dr McGill said that in several years, the smoking baboons should provide definitive information.

In the meantime, he suggests that some consideration should be given to a low tar, low gas, high nicotine cigarette, to keep people from increasing the number of cigarettes they smoke due to the pressure of nicotine addiction.

FDA wants cigarettes controlled

WASHINGTON — Anti-smoking groups are trying to pressure the Food and Drug Administration into regulating the sale of cigarettes as strictly as they plan to regulate saccharine.

The anti-cigarette Action on Smoking and Health (ASH) and other groups and individuals are prepared to file, with an FDA hearing officer, a petition that asks the agency to prohibit the sale of cigarettes containing nicotine, except by pharmacies.

The FDA has maintained it does not have jurisdiction over the sale and use of cigarettes, but the petition by the anti-smoking groups challenges this on legal grounds.

"This is one of those funny petitions that nobody says will work," said John Banzhaf III, a law professor at George Washington University, and the executive director and general counsel of ASH.

"I think it will work. Nobody has proved to me that it won't."

He recalled that in past campaigns his organization won the right to free air time to reply to cigarette commercials, won an eventual ban on cigarette advertising on the air, and got separate sections for smokers on airplanes, trains, and buses.

But a spokesman for the FDA said: "It is our clear understanding that Congress never intended for us or any other federal agency to regulate the use of cigarettes."

Addict-MDs unaware

CHICAGO — Almost one in nine American doctors has a drug or alcohol problem — and they are totally unaware of it.

These "chilling" figures come from the Illinois Medical Society which recently announced its detection program for "impaired" doctors at its state convention here.

"This is a very serious problem and for the first time we are really beginning to search out and treat sick physicians," said James Wes, chairman of the Illinois Medical Society Panel for the Impaired Physician.

The Illinois society estimates that of the state's 14,630 doctors, 11.5% may have severe drinking problems while 584 are narcotics addicts.

Meanwhile, the American Medical Association, realizing the seriousness of the drinking and drug problems, has begun to encourage state medical societies to start campaigns to detect "impaired" doctors.

Frank Chappell of the AMA says many doctors who are alcoholics and drug addicts don't know it.

"The big problem in this area is getting doctors to realize they have a problem." He said patients shouldn't worry because "most of these guys don't do anything until after office hours."

alcoholalcoholalcoholalcoh

factsheet

The drug ethyl alcohol or ethanol is the alcohol people drink. Alcohol can be made synthetically, or it can be produced naturally by fermentation of fruits, vegetables, or grains. In Ontario, beer contains 5% alcohol and most table wine from 10% to 14%. Fortified wines such as sherry, port, and vermouth contain 16% to 20% alcohol. Distilled spirits — whisky, rum, gin, etc — contain approximately 40% alcohol.

A 12 oz bottle of beer contains the same amount of alcohol as a drink containing 1½ oz of spirits, a five ounce glass of table wine, or a three ounce glass of fortified wine.

EFFECTS

As with any drug, the effects of alcohol depend on the amount taken at one time, the previous experience of the user — i.e. the drinker's tolerance to alcohol — and the circumstances in which the alcohol is taken, the place, the feelings of the user, the other people present.

Short term effects are those which appear rapidly after alcohol is taken and disappear after a few hours or a day.

(a) Alcohol decreases the activity of parts of the brain and the central nervous system (CNS) in proportion to the amount of alcohol in the blood stream. The drinker's blood alcohol level (BAL) depends in general on the amount consumed, rate of drinking, amount and kind of food in the stomach, and the drinker's size. For example, a 220 lb (100 kg) man would have a lower BAL than a 154 lb (70 kg) man if they both consumed the same amount of alcohol.

(b) When an average-sized man (154 lb/ 70 kg), with moderate drinking experience, has drunk the equivalent of three of four drinks, he can become dizzy and lose some coordination. The same sized person after six to eight drinks will tend to stagger, have double vision, and loss of balance. Though extremely large doses of alcohol can kill by knocking out the brain's control over breathing, this rarely happens because a person usually passes out before a lethal dose can be taken. The lethal BAL for humans is about 0.5% or six times the legal drinking-driving limit.

(c) Drinking heavily over a short period may produce a hangover (headaches, nausea, shakiness, and possibly vomiting) the next day. A hangover is the body's reaction to too much alcohol; in part it is related to alcohol poisoning, and in part is the body's reaction to withdrawing from alcohol.

Long term effects are those provoked by repeated use of alcohol over long periods of time.

(a) A level of physically hazardous consumption is reached (i.e. increased risk of liver scarring, certain cancers, ulcers, and heart diseases) when a person drinks, on the average, 10 centiliters or more of absolute alcohol per day. This is equivalent to nine ounces of 40% distilled spirits, 26 oz of wine, 21 oz of fortified wine, or six 12 oz bottles of beer per day.

About 328,000 people in Ontario consume at least 10 centiliters of alcohol per day; of these, approximately 145,000 consume more than 15 centiliters per day. The Addiction Research Foundation of Ontario defines anyone who consumes more than 15 centiliters of alcohol per day as alcoholic. This is equivalent to 14 oz of whisky, 37 oz of wine, 32 oz of foritified wine, or nine bottles of beer per day. Ontario's hazardous drinkers buy 40% of all liquor sold.

(b) As the person continues to drink, his tolerance for alcohol increases. This means he must increase his intake of alcohol to get the original effect.

(c) Because tolerance develops, many alcohol-dependent people drink steadily throughout the day but seldom seem to be intoxicated. This type of person may work reasonably well. His condition may go unacknowledged until severe physical damage develops, or until he gets sick and, confined to bed or in a hospital, experiences alcohol withdrawal symptoms.

(d) Many heavy drinkers suffer loss of appetite, vitamine deficiencies, stomach inflammation, infections, skin problems, and sexual impotence. Some also develop inflammation of the nerves, liver damage, and disorders of the heart and blood vessels. In severe cases, there may be confusion and/or loss of memory and blackouts. The loss of memory can be permanent.

(e) Rates of death are much higher for heavy drinkers than for light drinkers or abstainers, particularly from diseases of the heart and liver, pneumonia, cancer of the lung, throat, gullet, and mouth, acute alcohol poisoning, accidents, and suicide.

(f) The consistently heavy drinker becomes physically and psychologically dependent on alcohol over a period of time. Physical and psychological dependence also occurs in the taking of other drugs. Physical dependence occurs when body tissues have adapted themselves to alcohol in order to function "normally." People who are physically dependent on alcohol will have symptoms ranging from jumpiness to tremors and hallucinations when they stop drinking. Psychological dependence occurs when alcohol becomes so central to a person's thoughts, emotions, and activities that it is extremely difficult to stop using it.

Combining alcohol with antihistamines, marijuana, tranquillizers, barbiturates, or other "sleeping" pills, can be dangerous. Alcohol can intensify the effects of these drugs and vice versa. Many accidential deaths have been attributed to the combination of alcohol and barbiturates.

Though a majority of drinkers seem to use alcohol without damage to job, family life, or mental and physical health, impairment of bodily organs is known to exist if an average of about six drinks per day is taken regularly over a long period of time. *Nevertheless, it cannot be assumed that the daily use of smaller quantities of alcohol is safe.*

WHO USES ALCOHOL?

In Ontario, about 80% of people over 15 drink alcoholic beverages. In 1974, 85% of all Toronto grade 11 students and 92.6% of grade 13 students reported using alcohol.

WHY DO PEOPLE USE ALCOHOL?

Socially, people drink to enjoy a "high" feeling, or to overcome a "low" feeling. They also drink to relax and promote sleep, to relieve social or physical discomforts, to quench thirst, to sharpen appetite, to make a gathering more enjoyable, or as part of a social or religious ritual. Other reasons include curiosity, boredom, and going along with a group in which alcohol is frequently used.

Many people, however, drink to dull their feelings, to blot out their worries, to escape from personal responsibility, or to gain courage.

Many young people use alcohol to imitate their parents, other adults, or some of their friends — perhaps in an attempt to seem more sophisticated.

People are influenced to drink more or drink less by those around them. *There is a direct relationship between overall level of consumption and the number of alcohol-dependent people.* That is, a nation with a low per capita consumption of alcohol has a low incidence of heavy users, while a nation where alcohol is used widely and in which per capita consumption is high, has a proportionately higher rate of alcohol-related disease and death.

According to figures released by Statistics Canada, sales of all alcoholic beverages increased 11.2% in fiscal 1973-74 compared to fiscal 1972-73. Spirit consumption increased the most compared to the previous year, jumping by 11.65% compared to a 7.5% increase for wine, and a 5.3% increase for beer.

Since 1967, alcohol consumption has increased by 50% in Canada.

DRINKING AND DRIVING

Many traffic accidents are related to drinking. A blood alcohol level of 0.05% produces driving impairment in all people; driving with a level of 0.08% or greater is an offense under the federal Criminal Code. It is also illegal for a driver to refuse to take a Breathalyzer test or drive while impaired even if his blood alcohol level is lower than 0.08%. A 154 lb (70 kg) man's blood alcohol level will reach 0.05% by his taking two ordinary sized drinks over short period of time. *The less experience a person has had with either drinking or driving, the less alcohol it takes to impair driving performance.* High blood alcohol levels also have been found in many pedestrians hit by cars.

Moreover, out of 6,500 drownings in Canada between 1968 and 1972, alcohol was implicated in 42% of boating deaths and 28% of swimming deaths.

ALCOHOL AND THE LAW

Alcohol legislation is a joint responsibility of the federal and provincial governments. Many laws regulate the manufacture, distribution, possession, and consumption of alcohol.

In Ontario, it is illegal for anyone under the age of 18 to purchase alcoholic beverages.

The Journal

This page is presented as a service to our readers. Copies may be obtained in pamphlet form from: The Marketing Department, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Clip out this page

New Books

by RON HALL

The Effectiveness of Drug Abuse Treatment Volume IV: Evaluation of Treatment Outcomes for 1971-1972 DARP Admission Cohort

. . . edited by S. B. Sells and D. Dwayne Simpson

This volume presents five evaluation studies of treatment for drug abuse based on the Drug Abuse Reporting Program (DARP) Cohort 2 sample. The first section deals with patient classification measures, treatment types, and time in treatment, while the second section concerns itself with retention in treatment. The remaining parts consist of special studies of patterns of outcome associated with treatment effectiveness over the period of time in treatment.

(Ballinger Publishing Company, 17 Dunstar Street, Harvard Square, Cambridge, Massachusetts, 02138. 1976. 560p. $25.)

Employee Assistance Programs: Toward A More Productive Work Force

This report is designed as a general reference tool for planning and implementing an occupational program for city employees. It sets out general guidelines and program components which can be molded to fit the unique organizational structure of various cities. The topics which are covered include; a definition of terms, labor/management cooperation, coordination, policy statements, training and education.

(United States Conference of Mayors, 1630 Eye St, NW, Washington, DC, 20006. 1976. 36 p.)

Crisis Intervention: The Navy Alcohol Safety Action Program

This booklet details efforts aimed at the early identification of problem drinkers, and the prevention of their progression into chronic alcoholism. After a brief description of the use and abuse of alcohol and its application in terms of the Navy, the components of NASAP are outlined and the reasons for the program's usefulness are provided in terms of statistics applicable to the drinking patterns of Naval personel.

(Navy Alcoholism Prevention Program, Bureau of Naval Personnel, Washington, DC, 20370. 1976. 16p.)

The Alcoholism Digest Annual, Volume Three, 1974-1975

. . . edited by Georgiana P. Lira

This accumulation of the 12 monthly issues of *The Alcoholism Digest* contains more than 1,200 abstracts or summaries of reports, books, serial publications and other types of literature published in the digest from August 1974 to July 1975. The publication deals mainly with social, legal, familial, and psychological problems resulting from extensive alcohol use, and author and subject indexes make this an appropriate reference source for retrospective searching.

(Information Planning Associates, Inc, PO Box 6318 Northwest Station, 5632 Connecticut Ave, NW, Washington, DC, 20015. 1976 480p. $35.)

Other Books

Alcohol and Alcoholism — Evans, Roberta. Franklin Watts, New York, 1976. For juveniles; story of beer, story of wine, distilled beverages, alcohol and the body, alcoholism, index. 61p.

Buy And Bust: The Effective Regulation Of An Illicit Market in Heroin — Moore, Mark Harrison. D. C. Heath and Company, Toronto, 1977. Market structure, quantitative estimates for New York City, enforcement efforts, policy recommendations, figures, tables, bibliography, index. 291p. $12.70.

Bitter Pills — Mason, David, and Dyller, Fran. Citadel Press, Secaucus, 1976. Tranquillizers, analgesics, coronary vasodilators, antihypertensives, antiarthritics, sedatives, muscle relaxants, antiobesity drugs, index. 223p. $10.

Cocaine: A Drug And Its Social Evolution — Grinspoon, Lester, and Bakalar, James B. Basic Books Inc, New York, 1976. Historical aspects, effects, dependence, abuse potential, bibliography, index. 308p. $4.95.

Tissue Responses To Addictive Drugs — Ford, Donald H.T., and Clouet, Doris H. (eds). Spectrum Publications Inc, New York, 1976. "Proceedings of workshop sessions for the International Society for Neuroendocrinology," June, 1975. 704p. $35.

Baudelaire: Prince Of Clouds — de Jonge, Alex. Paddington Press Limited, New York, 1976. Biography, bibliography, index. 240p. $12.75.

The Employee Assistance Program — Wrich, James T. Hazelden, Center City, 1974. "A manual for management, organized labor, and occupational program consultants dealing with chemical dependency and other job performance problems." 96p. $1.95.

Alcoholism And The Brain — Bennett, A. E. Stratton Intercontinental Medical Book Corporation, New York, 1977. Disease concept, pharmacology and physiology, neuropathology, value of EEG and psychological testing, morbidity, mortality, medicolegal problems in industry, psychiatric disorders, rehabilitation. 86p. $9.75.

Alternatives To Alcohol Abuse: A Social Learning Model — Miller, Peter M., and Mastria, Marie A. Research Press Company, Champaign, 1977. Problem assessment, treatment plan, relaxation training, assertion training, social skills, self-control training, occupational skills training, evaluating the treatment plan. 190p. $8.25.

Dreams, Visions And Drugs: A Search For Other Realities — Cohen, Daniel. Franklin Watts, New York, 1976. Religious experiences, meditation, drugs, dreams, hypnosis, pains and endurance, visions, possession, experiments. 138p. $4.95.

Survey Of Cities Over 30,000 In Population And Other Selected Cities To Determine Local Drug Abuse Needs And Priorities — National League of Cities and United States Conference of Mayors. Drug Abuse Council Inc, Washington, 1976. 22p. $1.

Drinking Behavior, Attitudes, And Problems In San Francisco — Cahalan, Don, and Treiman, Beatrice. Bureau of Alcoholism, department of Public Health, San Francisco, 1976. "Report of a city-wide sampling survey of San Francisco residents aged 12 and older." 152p.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Canadian Congress of Criminology and Corrections 1977 — July 3-6, 1977, Calgary, Alberta. Information: Publicity Chairman, Canadian Congress of Criminology and Corrections, Box 1450, Main Post Office, Calgary, Alta, T2P 2M7.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference — FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall Street, Vanier, Ontario.

Alberta Alcoholism and Drug Abuse Commission Summer School on Alcohol and Drugs — July 24-29, 1977, Calgary, Alta. Information: Marg Bailey, AADAC, 812-16th Avenue SW, Calgary, Alta, T2R 0T2.

Institute on Addiction Studies — Aug 14-19, 1977, McMaster University, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Drive, Suite 603, Don Mills, Ont, M3C 1Y8.

2nd World Conference on Therapuetic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: conference headquarters, c/o The Portage Institute, 3418 Drummond Street, Montreal, PQ.

1977 World Congress on Mental Health — Aug 21-26, 1977, Vancouver, British Columbia. Information: Secretariat, World Federation for Mental Health, 2255 Wesbrook Mall, University of British Columbia, Vancouver, BC, V6T 1W5.

21st Annual Meeting of the American Association of Automotive Medicine — Sept 15-17, 1977, Vancouver, British Columbia. Information: Traffic Injury Research Foundation of Canada, 1765 St Laurent Boulevard, Ottawa, Ontario, K1G 3V4.

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

20th Annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9.

United States

35th Annual Session of the Summer School of Alcohol Studies — June 26-July 5, 1977, Rutgers University, New Brunswick, New Jersey. Information: Rutgers University, New Brunswick, NJ, 08903.

19th Annual Workshop on Problems of Alcoholism, Alcohol Education and Drug Misuse — June 30-July 19, 1977, Bloomington, Indiana. Information: Dr Ruth C. Engs, department of Health and Safety Education, HPER, Indiana University, Bloomington, IN, 47401.

The Committee on Problems of Drug Dependence 39th Annual Scientific Meeting — July 7-9, 1977, Cambridge, Massachusetts. Information: Jack H. Mendelson, director, Alcohol and Drug Abuse Research Center, McLean Hospital, 115 Mill Street, Belmont, Mass, 02178.

Issues in Alcoholism: 3rd Annual Colorado Summer School of Alcohol Studies — July 10-15, 1977, Denver, Colorado. Information: Alcoholism Council of Colorado, 2727 Bryant Street, Suite 310, Denver, Col, 80211.

7th Annual Kentucky School of Alcohol Studies — July 17-22, 1977, Morehead, Kentucky. Information: Kentucky School of Alcohol Studies, department of Human Resources, Bureau for Health Services, Room 266, 275 East Main Street, Frankfort, KY, 40601.

4th Annual Institute Summer Conference "Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking" — July 27-29, 1977, Seattle, Washington. Information: Roger A. Roffman, conference coordinator, Alcoholism and Drug Abuse Institute, University of Washington, Seattle. Wash, 98195.

International Doctors in Alcoholics Anonymous Annual Meeting — Aug 4-7, 1977, New York City. Information: Secretary, International Doctors in Alcoholics Anonymous, 1950 Volney Road, Youngstown, Ohio, 44511.

Employee Assistance Programs in Institutions of Higher Education — Aug 7-9, 1977, St Louis, Missouri. Information: Employee Assistance Program, 215 Columbia Professional Building, Columbia, Missouri, 65201.

Summer Institute of Drug Dependence — Current Issues, Research, New Directions in Alcohol and Other Drug Problems — Aug 15-19, Colorado Springs, Colorado. Information: Institute Coordinator, PO Box 1791, Colorado Springs, Col, 80901.

Tennessee School on Substance Abuse — Aug 21-26, 1977, Memphis, TN. Information: Sam Brackstone, program coordinator, Public Service and Continuing Education, Memphis State University, Memphis, TN, 38152.

6th Annual San Diego Summer Alcohol Studies and Substance Abuse Program — Aug 22-26, 1977, San Diego, California. Information: Karen Lockwood, Univ Ext Q-014, University of California, San Diego, La Jolla, CA, 92093.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977, Honolulu, Hawaii. Information: Rosa Torres, congress coordinator, 6th World Congress of Psychiatry, 1700 18th Street NW, Washington, DC, 20009.

1st International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation Inc, 222 East Redwood Street, Baltimore, MD, 21202.

Alcohol and Drug Problems Association of North America Annual Meeting — Sept 25-30, 1977, Detroit, Michigan. Information: ADPA '77, 755 Big Beaver Road, Suite 2018, Troy, Mich, 48099.

National Alcohol and Drug Treatment Outcome Evaluation Conference — Sept 26-27, 1977, Nashville, Tennessee. Information: Linda C. Sobell, director, Alcohol Programs, Dede Wallace Center, PO Box 40487, Nashville, TN, 37204.

Empirical Approaches to the Treatment of Alcohol and Drug Abuse — Oct 13-15, 1977, Charleston, South Carolina. Information: Catherine Young, department of Psychiatry, CSB, Medical University of South Carolina, 80 Barre Street, Charleston, SC, 29401.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

National Community Action Agency — Oct 29-Nov 3, 1977, Philadelphia, Pennsylvania. Information: Together Inc, PO Box 52528, Tulsa, Oklahoma, 74152.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, AZ, 85010.

2nd Southeastern Conference on Alcohol and Drug Abuse — Dec 1-3, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

Joint Conference of the American Association for Automotive Medicine and 7th International Association for Accident and Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

Abroad

4th Institute on Drugs, Crime and Justice in England — July 3-24, 1977, London, England. Information: Arnold S. Trebach, director, Institute on Drugs Crime and Justice in England, Center for the Administration of Justice, The American University, Washington, DC, 20016.

Dilemmas in Treatment — July 24-29, 1977, Venice, Italy. Information: Clara Shapiro, conference coordinator, Center for Policy Research, 475 Riverside Drive, New York, NY, 10027.

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977, Tokyo and Kyoto, Japan. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28-Sept 1, 1977, Bergen, Norway, Information: Peter Nathan, department of psychology, Rutgers University, New Brunswick, New Jersey, 08903.

9th Summer School on Alcoholism — Sept 10-16, 1977, Brighton, England. Information: The Secretary, Summer School on Alcoholism, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ.

Workshops on Alcoholism in Scandinavia — Oct 4-18, 1977, Denmark, Norway, and Sweden. Information: New York City Affiliate Inc, National Council on Alcoholism, 730 Fifth Avenue, New York, NY, 10019.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Special Symposium on Drug Dependence, 11th International Conference on Pediatrics — Oct 23-29, 1977, New Delhi, India. Information: Dr O. P. Ghai, All-India Institutde of Medical Sciences, New Delhi, India.

Asian Seminar on Research and Epidemiology on Drug Dependence — Nov, 1977, Chiang Mai, Thailand. Information: Prof Prasop Ratanakorn, director, Drug Dependence Research and Prevention Centre, 268 Rama 6, Phyathai, Bangkok 4, Thailand

26th Colombo Plan Consultative Committee Meeting — Dec, 1977. Information: The Colombo Plan Bureau, 12, Melbourne Ave, Colombo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside Lancashire and Cheshire Council on Alcoholism, B15, The Temple, Dole Street, Liverpool, L2 5RU, England.

The 'king' is not amused.

Ascendancy of heroin now seems assured in Western Germany

By Larry Scanlan

The old and the new in Hannover.

HANNOVER — Long before the city fathers here decided to revamp the city core and fill it with sleek architecture and kinetic sculpture, a great bronze statue of one of the Hannoverian kings stood riding his steed before the train station.

It stands there still, but like a remnant — a perch for the pigeons. On steps below the pedestal, young people will gather to drink, line up the emptied bottles, and sleep in the sun.

The king does not look amused. In light of the whole Hannover drug scene, drunkenness on the square seems tame: drug addiction among the young here is bad and growing worse, especially as the most dramatic rises in drug use have been in the drug the Germans simply call 'H'.

Heroin use, says Brigitte Hohnholz, a 27-year-old streetworker in Hannover, has just recently taken off here and the trends are ominous. "There is much, much heroin here and more cocaine is coming", she told **The Journal** in an interview.

Ms Hohnholz estimated there were about 600 "fixers" in this city of a half million people, compared with conservative estimates of 200 only two years ago. Available data appear to back her conjecture. Drug overdose deaths in the Lower Saxony area around Hannover rose from seven in 1975 to 19 a year later, including eight in Hannover.

The national West German picture is no brighter: drug deaths totalled 189 in 1975 and almost doubled the next year, and experts here are gloomy about 1977.

At a recent Hannover meeting on drug addiction, a sociologist involved in rehabilitation said there were an estimated 40,000 heroin addicts in West Germany. Police "guesstimate" there will be about 500 overdose deaths in 1977 and expect as many as 1,000 deaths next year.

Data at the Hannover Youth and Drug Centre where Ms Hohnholz is based show that in Hannover, at least, addicts are younger now — some as young as 15 —while local police figures on confiscated heroin show hefty increases, from 870 grams in 1974 to 1,240 grams in 1975 and 3,460 grams last year.

At the same time, the drug scene here is changing. "The people from the scene two or three years ago are still the same," says Ms Hohnholz. "They wear the same clothes, they talk, they wait. But the *new* people are quite, quite normal, have jobs, and many, many are fixing in private, shooting up by themselves. That's the big difference now".

She added that while two years ago the drug takers and the alcohol-drinkers never mixed company or addictions, this is no longer always true. When there's no H on the market, addicts will turn to a Valium and beer concoction, Valoron, or any other drug — "all they can get".

Edelhart Thoms, the young general practitioner who works in the drug information centre's ambulatory clinic, also commented on the new breed of "white collar" addicts. He knows four addicts who hold steady jobs and receive their heroin by mail from Amsterdam.

Dr Thoms, who has been working at the clinic for only seven months said that in that time he has seen more and more young alcoholics. About 10 so far have been 12 to 13 years old. Multiple drug use is also going up, he said, pointing out that Valium is sold quite freely in Hannover's discos where it is taken with beer.

The Valium source is assured, said Dr Thoms: "The kids can easily pressure their parents into getting it from their doctors or the kids go themselves and claim jangled nerves". He also emphasized that many young people come to the clinic with a physical problem such as parasites, liver disease, or venereal disease which is their "ticket" to the clinic. Once inside they actually wish to discuss a troublesome psychiatric or psychosocial problem.

The entrance to the Hannover Youth and Drug Centre does no justice to its interior.

Ms Hohnholz, asked why she thought the trend in Hannover is to more and heavier drugs, pondered a moment and then suggested: "They have no life aims, no goals, and one problem is unemployment". In 1976 the centre made contacts with 1,607 people under the age of 30, half of whom were unemployed and from the working class. Reports put out recently by the centre point out that many of its clients grew up without fathers, adding that there has been a noticeable increase in suicide attempts among the very young who lack social contacts.

These youths want escape, said Ms Hohnholz, and they ask themselves "what numbs the most?" Hashish, though still evidently available, has lost its appeal and is not even mentioned in drug circles. Following close behind heroin in popularity is cocaine, said Ms Hohnholz, who claimed the drug only appeared in Hannover six months ago.

Cocaine's popularity in the rest of the country is also soaring. Data provided by the Hannover youth centre show that while in 1975 only .8 kg of cocaine were confiscated by police in Lower Saxony, the figure was 2.4 kg in 1976. Meanwhile in Stuttgart, in southern Germany, three months ago five kg of cocaine with a street value of four million DM was confiscated. It was the largest haul of cocaine the West German police had ever taken.

Gernot Vormann, a psychologist in charge of the therapeutic communal houses which link with the Hannover Youth and Drug Centre, also focused on unemployment as a contributing factor to the dynamic growth in heroin use. And "heroin is in. It's a status symbol, the highest drug in the drug hierarchy. The Berliner Tinke (an opium or possibly morphine base 'cooked' with vinegar and then injected) used to be popular but no more. Now it's looked down upon."

The cost of H, however, seems to be going up with its increased use. Five months ago, Brigitte Hohnholz said the price of a Dutch gram of heroin was 50 DM ($22), later sold on the street for 150 DM ($65). H has now jumped to a 300-400 DM street price. Ms Hohnholz did not know why the prices had gone skyward, but she did say that dealers have begun to hold back supplies for up to three weeks in order to jack up its final sales price.

One tangible result of these price increases in H could be a rising crime rate, as addicts struggle to meet the steep prices. Here again the statistics are revealing. About 80% of the addicts Brigitte Hohnholz knows have criminal records. Last year in this city 40% of all crimes were drug-related and police here have estimated that crimes involving heroin users in 1977 will make up more than half of all crimes brought to court.

While heroin use, its price, and the crime rate, are all going up, the health of this growing number of addicts must decidedly be going down.

Dr Dirk Helmstaedt, a gastroenterologist at the medical school in Hannover, coauthored a study in 1974 of liver disease in drug addicts coming to the Hannover Youth and Drug Centre. Of 189 people studied only 10% steadfastly used their own syringes, resulting in the study's finding of either persistent or chronic aggressive hepatitis in 20% of patients studied. The average duration of intravenous drug abuse in the study group was an alarming 3.2 years.

But, while the bad news of heroin rocks Hannover and the rest of West Germany, the good news is that a unique therapeutic scheme for addicts here appears to enjoy a relatively high success rate. Using a "therapy chain" which begins with streetworkers and the Hannover Youth and Drug Centre, the plan for rehabilitating hard core addicts includes medical and therapeutic clinics, schools, after-treatment centres, communal houses, and job retraining workshops. All are run along the same conceptual line, which is gestalt therapy coupled with individual freedom and responsibility for the addict.

Even on the street, said Ms Hohnholz, there is no pressure put on the addict to give up his habit. He is only encouraged to think.

Addicts are allowed into the therapy chain only after they have shown willingness and determination to be rehabilitated. Even to enter therapy is made purposefully difficult. After thorough medical and dental checks, the addict must write a personal history and then weekly letters describing his motivation for therapy until a place is found for him. The seven communal houses of from 15 to 30 people are run on strict rules . . . up at seven each morning and no medication except Aponal. With a rigorous work schedule, therapy sessions, and retraining, addicts are kept very busy.

About two years later, equipped with schooling and perhaps a new trade, the former addict leaves therapy and many do indeed manage to cope. According to Dr Thoms, a followup study done between 1973 and 1977 of 90 former addicts showed that one-third were using no drugs, one-third were socially stable, using alcohol or drugs other than H, while the remaining one-third were addicted once again.

Addicts still come to the Hannover therapy chain from all over West Germany, said Ms Hohnholz. "Until two years ago it was considered experimental and the very best. Now other cities have similar institutions." Berlin, for example has a similar scheme, but Hannover is still recognized nationally as the leading exponent of chain therapy.

But even with such positive results in therapy, health care professionals here are not optimistic about the future. Amsterdam — the source of the H pouring into Hannover and where the annual intake of heroin is said to be worth 100 million gilders ($43 million) . . is geographically very close.

And, though the therapy scheme modelled in Hannover has had good results, most experts acknowledge that the key to therapeutic success is keeping the number of patients down. Overcrowding existing treatment centres would be a mistake. If the number of heroin addicts continues to grow, facilities must expand.

This seems unlikely for the moment. Lack of funds may kill the Hannover Youth and Drug Centre plus others like it, which experts here claim represent the all-important first link in the therapy chain. If the youth and drug centres collapse so will chain therapy.

Gernot Vormann told **The Journal** that Hannover's youth centre began as a federally funded project five years ago. In January, 1978, funding ceases and the West German government has said the states must now take over these working models. Only one centre per state (there are 10 states in West Germany) will receive federal money.

According to Mr Vormann, the state of Lower Saxony has said it has no money in its treasury to find the centres. Other states may take a similar line. Church groups and other agencies will probably step in with some aid, he said, but not enough. The estimated 100 youth and drug centres in West Germany could be in trouble. Many, said Vormann, have already folded.

The ascendancy of heroin as the new monarch in the Hannover and the West German drug scenes, seems assured unless some break occurs in the pattern of recent years. The therapy scheme which appears capable of stemming at least some of the tide is in financial straits. Unemployment, fingered as a causal factor in the new heroin boom, is an economic fact of life and shows little sign of disappearing here or anywhere else.

From atop his horse, the king looks out on Hannover's Ernst Augustplatz and no, he is not amused.

This West German anti-heroin poster translates into: 'The End — Curiosity was the beginning — Drugs kill.'

THE BACK PAGE

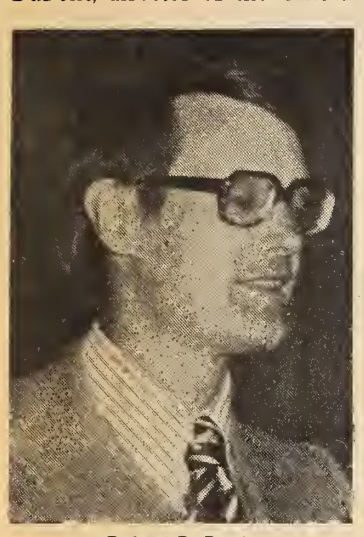
The Journal

Vol. 6 No. 8 2nd Class Mail Reg. No. 2776 **Published monthly by Addiction Research Foundation of Ontario** TORONTO, August 1, 1977

Cannabis dilemma plagues DuPont

By Harvey McConnell

CAMBRIDGE, MASS — Doubts about the wisdom of having supported decriminalization of marijuana are now haunting Robert DuPont, director of the United States National Institute on Drug Abuse.



Robert DuPont

Dr DuPont told fellow scientists here at the conference of the Committee on Problems of Drug Dependence: "Our scientific concern with the issues in the marijuana field has tended to promote marijuana or at least to be very permissive with respect to marijuana use."

A change in the law on private possession of small amounts of the drug has been reduced by most people to a for-or-against position, he said.

"Any attempt to talk about decriminalization communicates the message that marijuana use is okay, instead of seeing it as a very clear and needed reform of taking the marijuana user out of prison, and removing the threat of prison.

"The move toward decriminalization is, in fact, interpreted widely by the public as a move towards permissiveness with respect to marijuana.

"It is of sufficient concern to me that I begin to wonder about the wisdom of the position I have taken for the last several years. This is not because I have any doubts it is the right position, but it has such a surplus meaning when it comes to the public, I am concerned the net effect is actually a negative effect, rather than a positive effect."

Dr DuPont said the dilemma is whether one can be concerned about the science of the issue, be attuned to and responsive to the knowledge generated, and the uncertainty associated with this knowledge generation; support removal of criminal sanctions; "and still effectively act to curb the use of marijuana.

"Or, is it inevitable that these two positions will be seen as the promotion of marijuana use-age?"

He believes questions about

(See — Values — page 7)

Alcohol, tobacco industries too powerful

Gov't fears getting tough

By Karin Pargas

WINNIPEG — The Canadian government is afraid to get tough with the alcohol and tobacco industries because of the vested interests created by the demand for these substances.

Yet, it has not hesitated to take dramatic action eventually to ban saccharine in which interest is negligible, and simply because cancer was seen in some rats, according to Donald Faris.

Mr Faris, a member of the Legislative Assembly for Saskatchewan, was speaking here to the 12th annual conference of the Canadian Foundation on Alcohol and Drug Dependencies.

He urged several new policy directions for the government and said for these policies to be implemented, alcohol and tobacco manufacturers should be nationalized.

His suggestions include:

- an immediate, total, national ban on alcohol and tobacco advertising and promotion, together with new anti-smoking, anti-drinking, and positive life-style advertising;
- development of a national pricing policy to maintain the relative price of alcohol and tobacco, and an eventual increase in these prices so consumption may fall to more socially acceptable levels;
- an end to further liberalization by government of liquor laws; and
- establishment of a national legal drinking age and smoking age at 19 or 20 years.

As for vested interests, he said: "In the case of alcohol and tobacco, there is a large and powerful group of people who profit from their trade. These include agricultural interests, manufacturers, and retailers. These include multi-national corporations and federal and provincial governments.

"If our national government will not take serious action to prevent the problems produced by the use of alcohol and tobacco because they fear the influence of industry, then I assert that industry is too powerful.

"The human damage, the personal suffering, the broken homes, the unhappy children, the sickness of body, mind, and spirit associated with the heavy use of alcohol and tobacco in our society, are more than I believe our society should bear."

He said it is time both private industry and government stop their present course of action and start to behave responsibly.

Cocaine: a ton a week into the US

CAMBRIDGE, MASS — Cocaine, now entering the United States at the rate of a ton a week, is presenting a "terrible problem" for Peter Bourne, US presidential adviser. (See below).

While the price remains at up to $100 a gram, cocaine is not a serious health hazard. At the same time, the enormous profits from cocaine have become a major source of both hard currency and corruption in Latin America.

Dr Bourne said: "If there is one drug that is going to be the drug of the 70s that we have to deal with, it is cocaine. And if there is one drug I have a terrible problem with, it is cocaine."

A just-issued National Institute on Drug Abuse report says eight million Americans have tried cocaine and some one million have used it in the past month.

In an address to the conference here of The Committee on Problems of Drug Dependence, he said when he took office he was amazed to find the level of ignorance that existed in the government about cocaine.

Officials in the Latin American section of the state department "were absolutely convinced cocaine was a highly dangerous and highly addictive drug, and we needed to spend large amounts of money to deal with cocaine cultivation in Latin America." They believed also thousands of Americans died annually from the drug.

Last year, at the urging of the Latin American section, then Secretary of State Henry Kissinger offered Bolivia $45 million to help develop a crop substitution program for coca. This misinformation and misunderstanding about cocaine means Bolivia feels it has a solid commitment of money Dr Bourne believes "could be enormously better used elsewhere."

Present estimates are that cocaine comes in at the rate of a ton a week and sells for up to $100 a gram. But the death rate here from the drug is very low — best estimates are that 52 persons have died from overdoses in the past three years.

Dr Bourne said: "The question is, if cocaine is coming in large quantities, and it is not causing serious health hazard, do we really need to do something about it?"

The drug is now expensive to

(See — Increased — page 7)

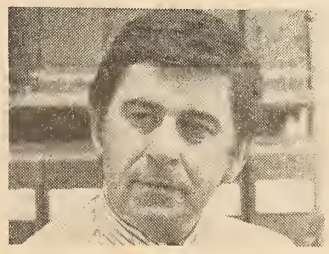
Bourne's office gets axed

WASHINGTON — President Jimmy Carter has abolished the Office of Drug Abuse Policy as part of his White House reorganization.

ODAP's director, Peter Bourne, will stay on in "my original position as special assistant to the president with a general assignment."

Dr Bourne, who had been confirmed in office by the Senate only six weeks previously, added he will be "devoting my efforts primarily to the health and international human needs areas, as well as continuing to coordinate the federal effort in drug abuse."

The reorganization plans said ODAP functions "can be performed by a smaller staff reporting to a presidential adviser."



Peter Bourne

Eight years after commission of inquiry

Britain eases up on marijuana laws

By Thomas Land

LONDON — Imprisonment of first offenders on summary conviction for possession of cannabis is to discontinue in Britain under the Criminal Law Bill currently passing through parliament.

The change reflects new thinking among research scientists who have failed to identify medical evidence to back the still widespread social disapproval of cannabis consumption, despite many years of painstaking investigations. It also follows legislative changes in Western Europe and North America where control over the weed is being relaxed to enable law enforcement agencies to deploy their full resources against hard drug trafficking, which is increasing.

Merlyn Rees, the British Home Secretary (a kind of minister of justice), told the House of Commons that the administration has accepted a recommendation by the Standing Advisory Committee on the Misuse of Drugs that a person with no previous conviction should not face the possibility of imprisonment on summary conviction of possessing cannabis. Maximum penalties for possession have been set hitherto at six months' imprisonment or a £400 (about $750) fine, or both.

Times change. When a distinguished committee of inquiry, headed by the Baroness of Wootton of Abinger, recommended a more lenient attitude towards cannabis eight years ago, the British Home Secretary of the day declared that it would be "sheer masochism" to add to the country's "social evils" by such legislative action. He was James Callaghan, the present Prime Minister.

The Baroness now observes that "already in the United States, eight states have taken steps to decriminalize the possession of cannabis while at least a score of others are contemplating similar action; and now we hear that President Carter's administration is giving federal blessing to this policy. Other governments in Canada, in Europe, and in Australia are following the same path."

The Wootton committee considered at the time that perhaps 30,000 to 300,000 Britons might have tried cannabis at least once. Five years later, another survey conducted by the British Broad-

(See — UK — page 7)

Regular features

This month, The Journal introduces a new, regular feature — Projections. Projections will provide readers with a selection of evaluations of audio visual materials relating to the alcohol and drug dependence field. The evaluations have been prepared by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. Projections appears this month on page 14.

Smoke–how bad for babes?

By Cora McCann

CLEVELAND, OHIO — Babies of smoking mothers have a reduced supply of oxygen, begin life with a higher lead level which environmental contaminants may later raise to a critical level, and are smaller and less healthy than babies of non-smoking mothers.

These are among results of a study to determine just how much damage smoking can cause in the unborn infant. The study was conducted by Paul and Betty Kuhnert of Cleveland Metropolitan General Hospital.

The Kuhnerts, a husband/wife team at the hospital's perinatal clinical research centre, found that the 49 infants of non-smoking mothers had a mean level of 15 micrograms of lead per 100 milliliters of whole blood, while the 22 infants of smoking mothers averaged 17 micrograms of lead per 100 ml.

"This increased lead level inhibits delta-aminolevulinic acid dehydratase, an enzyme involved in the synthesis of hemoglobin, which is in the red blood cell," said Dr Betty Kuhnert.

Hemoglobin is responsible for transporting oxygen.

"Lead is not a normal constituent of the human body, and any lead that is found there is an environmental contaminant," said Dr Paul Kuhnert.

Each cigarette smoked provides one to two micrograms of lead, they added.

Smoking during pregnancy also causes lower birth weight. The smoking mothers in the study gave birth to infants weighing an average of 7.05 lbs., while infants of non-smokers averaged 7.61 lbs.

"Not only do you have a higher lead level, but there is an increased risk of morbidity in these babies," said Dr Betty Kuhnert. "Low birth weight babies in general have more problems than other babies. So the mother not only exposes her baby to more lead, but also to nicotine and carbon monoxide and all kinds of other things, so that the baby gets less oxygen and fewer nutrients."

The Kuhnerts found no evidence of prematurity or prematurely ruptured membranes in smoking mothers, as other studies have, but they say they probably would in a larger sample of mothers.

Just how do these additional two micrograms of lead affect the infants?

"Although these lead levels in the infants are not toxic, you should remember this is what they are starting with. If they're exposed to additional lead later in life and begin to reach higher and higher levels, this can cause mental retardation and learning disabilities," Dr Betty Kuhnert explained. "Lead poisoning is a very serious problem, particularly in the inner city."

All of these mothers lived in or very near Cleveland, and apparently the lead found in non-smoking mothers is a result of industrial pollution and automobile exhaust.

"Even in the uterus, these babies are exposed to pollutants, and this does affect their development," said Dr Betty Kuhnert.

"We hope to begin studying smoking and non-smoking mothers living in suburban Cleveland soon," Dr Paul Kuhnert added. "We think we might find that those mothers living away from industrial pollution and a high density of mobile traffic have lower lead levels than those mothers living inside of Cleveland."

The Kuhnerts expect to follow up the infants in a few years.

Smoking during pregnancy can result in the accumulation of lead in both the mother and her fetus, according to a study conducted at Cleveland Metropolitan General Hospital.

Glucagon—it adds little to conventional therapy

TORONTO — Glucagon in addition to conventional therapy is no better than conventional therapy alone for the treatment of alcoholic pancreatitis, say two Cleveland researchers.

A. Olazabal and R. K. Fuller, from the department of medicine at Cleveland Veterans Administration Hospital, told a meeting here of the American Gastroenterological Association and the Gastroenterology Research Group that they base their opinion on a randomized, double blind study of 26 patients with pancreatitis associated with alcohol ingestion.

The subjects were randomly assigned to receive either glucagon or placebo in addition to intravenous fluids, nasogastric suction, and meperidine as needed. Each patient received either 1.0 mg of glucagon or placebo dissolved in 1 ml of isotonic saline intravenously as an initial bolus followed by glucagon or placebo in isotonic saline at the rate of 0.25 mg/hr until either the patient was pain free for 24 hours or 120 hours had elapsed since the start of treatment.

According to Drs Olazabal and Fuller, the patients were examined and interviewed at 8 am, 3 pm and 11 pm. Blood and urine specimens were obtained at these times for amylase and creatinine determinations and blood was also obtained at 8 am for lipase and methemalbumin determinations.

The team found no statistically significant differences between the group which received glucagon and the group which did not in duration of any of the following symptoms: abdominal pain, nausea, or anorexia; abdominal tenderness, absence of bowel sounds, tachycardia, or fever.

Similarly there was no statistical difference in laboratory tests for abnormal elevation of serum amylase, renal clearance of amylase to creatinine, blood lipase, or leukocytosis. Nor was there a statistically significant difference in the number of meperidine injections received per subject.

In addition to their positions at the Cleveland VA Hospital, Drs Olazabal and Fuller hold appointments at University Hospitals of Cleveland and Case Western Reserve University School of Medicine.

Drinks dose shifts sphincter function

TORONTO — Acute ingestion of large quantities of alcohol may be needed before disruption of esophageal and lower esophageal sphincter function is observed.

A team from the department of medicine at Temple University in Philadelphia says although dysfunction of the esophagus and lower esophageal sphincter (LES) has been described after alcohol ingestion, the quantitative effects of graded doses of alcohol have not been reported.

E. M. Mayer, C. J. Grabowski, and R. S. Fisher, told the American Gastroenterological Association and the Gastroenterology Research Group here that to get more precise data on this problem they subjected 18 normal volunteers to esophageal manometric studies before and after intraesophageal infusion of alcohol at doses of 60, 80, and 100 gm administered over a 15 minute interval on separate days. Corresponding mean serum concentrations of alcohol were 73, 102, and 117%, respectively.

The team measured amplitude of contraction and velocity of propagation in proximal, middle, and distal segments of the esophagus; resting LES pressure; and pressure responses to maximal doses of pentagastrin, edrophonium, and bethanechol.

Test results indicated both esophageal and LES function were affected minimally at a serum alcohol concentration of 73 mg%. In contrast, when the blood alcohol concentration was 117 mg%, the alterations in esophageal and LES function were more pronounced.

The amplitudes of esophageal contraction were decreased as follows: proximal segment, 30.6 + 3.2 to 22.9 + 2.4 mmHg; middle segment, 31.6 + 3.3 to 23.4 + 1.7 mmHg; distal segment, 34.9 + 3.2 to 25.7 + 2.3 mmHg. The maximal LES pressure responses to pentagastrin, edrophonium, and bethanechol were each reduced significantly as follows: 31.6 + 4.6 to 14.6 + 3.6 to 10.4 + 3.1 mmHg, and 25.9 + 4.7 to 16.4 + 3.7 mmHg respectively. Neither propagation velocities of peristaltic waves nor resting LES pressures were changed by administration of alcohol.

As a result of their study, the Temple University investigators drew three conclusions: that alcohol, administered acutely, altered both esophageal and LES function; that the effects of alcohol were dose related; and that 70 mg% was the approximate threshold serum concentration both for the effects on the body of the esophagus and LES.

Social scientists get theirs in new canto

By Wayne Howell

In *Divina Commedia* the great 13th century Florentine poet Dante Alighieri embarked upon an imaginary trip through Hades accompanied by the Roman poet Virgil (the chronicler of the underworld adventures of the Trojan hero Aeneas) who served as his guide and companion.

Dante scholars have until now always considered the *Inferno* part of *The Divine Comedy* to be complete and thus there are many who question the authenticity of the following fragment from Dante's epic poem which was allegedly discovered six months ago in the ancient library at Ravenna.

The disputed fragment of Dante's *magnum opus* would appear to be Canto VI½, coming between Canto VI wherein Dante describes how the gluttonous are punished (their eternal torment is to lie in the mire under a continual and heavy storm of hail, snow, and discolored water) and Canto VII wherein Dante describes the eternal doom that awaits the prodigal and the avaricious, which is to meet in direful conflict, rolling great weights against each other with mutual upbraidings.

Unlike the other 34 Cantos, there is no "argument" to serve as an introduction to the disputed fragment of *Divina Commedia* but it appears that Virgil was showing the poet an area of Hell especially reserved for social scientists whose earthly sins had been of a verbal sort . . .

Trendy jargon boomed aloud
Upon the cringing whimpering crowd;
The souls below did weep and wail
But pitiful crys did naught avail;
Jargon spewed from giant woofers,
Buzz-words shrieked from evil tweeters;
The Devil's watts drove both channels
And words like viable *fell like anvils,*
Upon the cowering horde.
Through endless days and endless nights
Dysfunction *screamed from towering heights,*
Reverb'ed from fetid stinking fens,
And echoed in sulphurous glens,
Until the wretched souls below
Writhed beneath the acoustic blows;
Driven to the brink of madness
They prayed for death with fervent gladness —
But it was not to be.
Modality, Interface, Parameter, *and more*
Blared on and on in endless roar;
The jargon split and rent the air
Oblivious to the victims' prayers;
Satan's Sonys could easily handle
One hundred watts on either channel:
Multifactoral *screamed from Olympian heights,*
And echoed in the gruesome light
—A Hellish thing to bear.
"Mercy, Mercy," the victims cried,
"We ne'er abused those words," they lied,
"O God in Heaven hear our plea,
Release us, save us, set us free."
But all they heard was the Devil's chortle
As he turned his hand to the Amp's big throttle;
More jargon boomed from gargantuan speakers:
No respite for the buzz-word freakers,
Who writhed for evermore.

(Wayne Howell is an Ottawa physician and freelance writer.)

San Francisco is taking offence at NIDA report

SAN FRANCISCO — A leader in the drug abuse field here has challenged the findings of a federal drug abuse study showing that the San Francisco Bay area has the highest per capita number of heroin addicts among metropolitan areas in the United States.

The report, issued by the National Institute of Drug Abuse, pegged the number of addicts in the San Francisco area at 916 per 100,000 (28,000).

On a per capita basis, Los Angeles followed with 864 per 100,000 then Phoenix with 796 per 100,000.

The study was criticized by James Scannell, San Francisco administrative coroner and president of the San Francisco Coordinating Council on Drug Abuse.

He believes the figures are overblown to a degree that they "bad rap" the city and added that if they are valid, then the federal government should be pouring vastly increased sums into local programs to help cope with the situation.

"No one knows the true figures," he said.

"But assuming they are valid, then we should have hospital beds to care for 6.000 women addicts, and in the whole of the Bay Area, there are only 60 beds."

NIDA's findings were based on five factors: emergency-room reports, coroners' statistics, rate of admissions to drug abuse treatment programs, and the price and purity of heroin.

The five indicators, according to NIDA's chief of forecasting in the division of resource development, Philip Person, are used to give estimates for each metropolitan area.

At the Haight-Ashbury Free Medical Clinic, researchers' figures differ markedly from those released by NIDA.

The free clinic estimates the heroin use for the Bay Area as somewhere between 6,000 and 9,000 — only a third of the federal government's findings.

Robert DuPont, director of the National Institute of Drug Abuse, in releasing the study, acknowledged that calculating the number of heroin addicts in the nation as well as in each city "long has been a guessing game."

"Although this important new study has added a measure of credibility to the process, the study used a complex trail of assumptions and the figures themselves remain estimates."

In head and neck cancers

Alcohol may not deserve any blame

By Thomas Hill

MIAMI BEACH — The idea that alcohol use increases a person's risk of developing head and neck cancer is an old one and statistics seem to support it. But not everyone agrees that alcohol deserves the blame.

Although it's true heavy alcohol users appear to have five to 10 times more than the average person's chance of getting cancer of the mouth, pharynx, larynx, and esophagus, the fact is no one has really separated the influence of alcohol from that of cigarette smoking or diet.

Heavy drinkers tend to be heavy smokers, and they often have bad nutritional habits. So what causes the cancer — the alcohol, the cigarettes, or the diet?

Joseph G. Feldman, in the department of environmental medicine and community health at the State University of New York, Downstate Medical Center, Brooklyn, has tried to separate out these three risk factors.

What he did, in essence, was to compare the drinking, smoking, and dietary patterns of a group of head and neck cancer patients with the same patterns for a matched sample of alcoholics. Then he made a similar comparison for a control sample of patients with cancers at sites that seemed unrelated to smoking or drinking.

Reporting his study here at the annual meeting of the American Public Health Association, Dr Feldman explained he had matched these samples of alcoholic patients to three samples of head and neck cancer patients on the basis of age, sex, race, and socioeconomic status.

One of these samples of alcoholic subjects was also matched by level of smoking and dietary intake, leaving alcohol consumption as the only important difference between the two groups.

The second sample was matched for the same general characteristics and also for level of alcohol consumption and dietary intake, with smoking left as the only variable. In the third sample of alcoholics, the only unmatched factor was dietary intake.

Analyzing the results of these comparisons as they related to smoking and drinking, Dr Feldman said in the samples matched for tobacco use, alcoholic subjects consumed 4.9 oz more whisky (or its equivalent) than head and neck cancer patients. Compared to patients with other types of cancer, matched for tobacco use, the alcoholics consumed 7 oz more.

Data for the samples matched by alcohol use found head and neck cancer patients smoked a daily average of 3.9 more cigarettes than the alcoholics who had no cancer. Patients with other types of cancer smoked 5½ *fewer* cigarettes per day, on average, than did their matched alcoholic subjects.

When he separated diet data in the same way, Dr Feldman found no significant difference in the proportion of the different groups having a poor dietary intake.

"These findings suggest that it is the *combination* of alcohol and tobacco use that increases the risk of head and neck cancer," concluded Dr Feldman.

He based this conclusion on two lines of reasoning:

1) that head and neck cancer patients smoked more than their matched alcoholic subjects, whereas other cancer patients smoked less;

2) that in samples matched by tobacco use, both head and neck and other cancer patients drank significantly less than their matched alcoholic subjects.

"If alcohol alone increased the risk of head, and head and neck cancer, then no differences should have existed in levels of smoking between head and neck cancer patients and alcoholic subjects who drank similar amounts of alcohol," Dr Feldman added.

"The heavier smoking among head and neck cancer patients suggests alcohol acts either as a co-carcinogen or as a promoter of tobacco carcinogens."

Canadian health survey is in pilot stage in Quebec

MONTREAL — A federal health survey ultimately intended for all Canadians is now in its pilot stage in Quebec.

Four hundred families will be asked to complete a confidential questionnaire concerning lifestyle, smoking, alcohol use, exercise, and driving.

In announcing the involvement of 13 communities in the pilot stage, John Coombs, statistician and survey manager, said "previous studies always dealt primarily with sickness more than health."

The Quebec study is intended to smooth the way for a Canada-wide poll scheduled for March, 1978. The project is sponsored by a $700,000 grant from the department of national health and welfare and $1,000,000 from Statistics Canada.

Next year's national survey will provide data on the health status of, and risks to, the Canadian population.

Follow-up to the questionnaire, involves second visits to one-third of the participating households. At that time, an interviewer and a nurse will conduct a series of tests and measurements relating to height, weight, blood pressure, heart efficiency, etc.

Naloxone detoxification safe, rapid

SAN FRANCISCO — Using naloxone-precipitated withdrawal, it is possible to rapidly and safely detoxify low dose heroin and methadone addicts and to transfer them onto maintenance doses of naltrexone.

The most rapid procedure enabled patients to make the transition from opiate dependence to naltrexone maintenance within 48 hours after their last opiate dose, Richard S. Kestenbaum told the 31st annual convention of the Society of Biological Psychiatry.

The procedure was found to be safe in that only minimal changes in vital signs were observed, said Dr Kestenbaum of the division of drug abuse research and treatment, department of psychiatry, New York Medical College.

He reported using naloxone detoxification for periods of one and two days.

In the two-day procedure, 20 subjects dependent on 20-100 mg per day of methadone were gradually detoxified as outpatients then admitted to the study ward.

When they reached a daily methadone dosage of 5-20 mg they received one day of methadone placebo.

The naloxone was administered on the first day in six intramuscular injections of 0.8 mg every three hours for a total of six injections; on the second day 2.0 mg every six hours for a total of three injections.

On the third day, each patient was given an intravenous injection of 1.2 mg naloxone, the "Narcan Test," to determine whether he could be started on naltrexone without precipitating abstinence.

The first injection of naloxone produced the most severe discomfort based on a rating scale of abstinence symptoms and signs; but subsequent injections were more readily accepted so that by the end of the first day naloxone was no longer precipitating abstinence.

On the second and third days naloxone precipitated renewed abstinence, which again subsided with time.

The Narcan Test ruled out 12 of the 20 subjects from being started on naltrexone.

The other eight were started on a 100 mg dose and during three days had no significant changes in heart rate, blood pressure, temperature, or respiration.

In the one-day procedure, 13 subjects were stabilized on 5-20 mg per day of methadone and received injections of naloxone after one to three opiate-free days.

The dosage schedule was 1.2 intramusuclar injections every half hour until two successive injections produced little or no abstinence or gastro-intestinal symptoms, then 100 mg oral doses every hour for two hours alone with naloxone injections.

Naloxone was then stopped and oral naltrexone was given in doses of 10 mg at hourly intervals, beginning with 5 mg and ending with 50 mg.

The course of abstinence when injections were spaced 30 minutes apart was similar to the two-day procedure when injections were three hours apart.

The intensity of withdrawal climbed to peak level over the first two or three injections then reversed course and declined.

The number of injections the subjects received before satisfying the criterion that two successive injections produce little or no abstinence ranged from three to 14 with an average of seven.

Subsequent administration of oral naltrexone did not precipitate abstinence, nor did they interfere with the continuing decrease in the severity ratings. Because the present findings are preliminary, Dr Kestenbaum said that the procedure should be applied with caution.

Further studies are needed to learn how such parameters as length of opiate addiction, level of dependence and ancillary medications influence response to naloxone, as well as the relative effectiveness of different naloxone dose schedules, he said.

Non-smokers compensated

WASHINGTON — A United States government employee has been awarded $18,200 a year in compensation following claims his chronic illness had been caused by cigarette smoke generated by his fellow office workers.

Werner Peterke, who worked for the Social Security Administration in Baltimore, is among a number of non-smoking federal employees who have filed suit in US District Court here. They want smoking allowed in only designated areas in federal buildings and improved ventilation.

The plaintiffs claim their health has suffered because they have had to inhale others' tobacco smoke.

Mr Peterke has been awarded compensation by the federal employee compensation office. His doctor diagnosed his condition as asthmatic bronchitis.

He said he wants to go back to his job one day and hopes the lawsuit will make that possible.

Lawyers for the plaintiffs said they had resorted to the courts because efforts to seek relief through other federal agencies had proved fruitless.

Prisoners should be on methadone

SACRAMENTO — Prisoners on methadone before imprisonment should have the right to continue treatment, according to a state task force report ordered by Jerome Lackner, California State Health Director.

The report which also recommends sexual freedoms — conjugal visits and the opportunity to engage in sexual behavior — will be submitted to the state department of corrections.

A quit smoking tip: try a bit of knitting

LONDON — Want to quit smoking *and* beat the energy crisis? Knit a sweater.

That's the advice of Charles Fletcher, a British physician who formerly chaired and still sits on the Royal College's committee on smoking and health.

A recent article in London's *The Sunday Times* included a picture showing Dr Fletcher — in tweed suit and bow tie — knitting a blue angel top for his grandchild, and although the picture is slightly comic, Dr Fletcher's message is dead serious.

He feels that keeping the hands busy is helpful to those trying to kick the cigarette habit. A former smoker who contracted tuberculosis in the 40s, Dr Fletcher took a tip from a colleague when he found it difficult to stop smoking. He took up knitting. It worked.

The latest Royal College report on smoking and health, published only recently, blames smoking for 25,000 deaths in Britain in 1974, noting that generally each cigarette smoked chips away five and a half minutes of the smoker's potential lifespan.

"Young people may think they do not mind if they lose 10 or 15 years of life but they will care when they get to my age," warns Dr Fletcher. The report further pointed out that in 1975 manufacturers peddling tobacco spent $137 million in promoting cigarettes.

Although women, says the report, seem to be smoking more in Britain, professional people have been smoking continually less since 1958 — only one in three now smoke. Perhaps, like Dr Fletcher, more professionals are heaving their butts and pipes in favor of a salubrious pair of knitting needles. The thought is, well, warming.

Reasons for smoking are many and varied

Most effective treatment is geared to individual

HAMILTON — The pattern of reasons for smoking varies so much among and within individuals that the best anti-smoking program is one tailor-made to the individual's pattern, says a University of British Columbia psychologist.

J. Allan Best says there has been an "explosive increase in programs and literature on how to quit smoking, with the increased awareness of the adverse health effects".

He reviewed the existing literature in preparation for the second international symposium on compliance, attended by researchers and clinicians from eight countries and held at the McMaster University Medical Centre.

"Nicotine plays a role in why people smoke, but mood, social situations, and learning behavior are also factors, and for a large part, people smoke for no good reason at all."

He grouped existing programs into five categories: groups, educational and attitudinal change, pharmacological, hypnosis, and behavior modification.

Control studies of group dynamics programs show only 15% to 20% quit in the long range, and the educational and attitudinal change approach is ineffective for behavior change, although both may have some value as part of a more comprehensive package, Dr Best said.

Pharmacological regimens by themselves have consistently negative results because the problem is more than one of pharmacological dependence. These programs include products like Nicoban, or chewing gum containing nicotine.

Studies of hypnosis are hard to evaluate, Dr Best said, and reported results are so highly variable they range from 0 to 100%. It seems more successful when combined with other techniques, or as an aid in teaching alternative behavior.

The rapid-smoking technique, where a person chain smokes as many cigarettes as he can, is unpleasant, but "is firmly established as the most effective way to get stopped", Dr Best said. "It seems to reliably produce good short term results, and moderate long term ones."

Getting off, and keeping off, cigarettes are two distinct processes, and while aversion techniques may be effective in producing the initial behavior change, self-control techniques may play a role in maintaining the change, which is the bigger problem.

Devices to cut back gradually, like automatic locks on cigarette boxes, and pocket timers, have shown generally negative results: more success is achieved with abrupt quitting. Relaxation techniques for anxiety management don't effect the smoking that isn't associated with tension.

Dr Best said the best treatment probably is an individualized one that considers the specific pattern and needs of the smoker, provides effective and appropriate alternative behavior in smoking situations, is maintenance-oriented, and comprehensive.

He considered a good program one that had a 40% to 50% success rate at one year.

'The rapid smoking technique . . . '

Smoke until exhausted: MD

LONDON — Michael Russell, a psychiatrist at London's Addiction Research Centre, Institute of Psychiatry, believes tobacco users either smoke for psychosocial, sensory, or indulgent reasons; or to relieve unplesant withdrawal feelings.

The latter "drug dependent" smokers tend to have high blood levels of nicotine and carbon monoxide and benefit most, therefore, from the therapeutic use of chewing gum containing nicotine, he claims.

For smokers in the psychosocial group, Dr Russell believes the best approach is the "rapid smoking method." The smoker is urged to light up and puff regularly, without inhaling, every six seconds, and then to repeat the process with a second cigarette, puffing away rapidly until exhaustion sets in.

This procedure, he claims, will blot out the urge to smoke for from five to six hours. The patient should repeat it every day until the desire to smoke has disappeared completely.

New Brunswickers call for raised drinking age

By John Carroll

MONCTON — There are growing calls in New Brunswick for upward revision in the drinking age from the present 19 years to 20 or 21.

In June, the 49th annual meeting of the New Brunswick Home and School Federation called for provincial legislation to raise the legal drinking age although no specific date was recommended by the smoking and health committee.

Richard Hatfield

In its deliberations, the federation, through the smoking and health committee, came down heavily not only on alcohol, but on smoking.

Another recommendation was that the provincial government be approached by the federation with a request for the prohibition of smoking rooms in schools as well as designated smoking areas. The sale of cigarettes by school canteens and through vending machines located on school property was also condemned.

Other resolutions involved recommendations that the sale of tobacco products by vending machines be prohibited entirely in New Brunswick, that all forms of tobacco advertising be banned, and that five cents from the sale of every package of cigarettes sold in the province be turned over by the government to the New Brunswick Council on Smoking and Health for use in the prevention of tobacco-related illnesses.

The federation will ask the appropriate provincial authorities to enforce existing legislation regarding the sale of tobacco to people under 16, to enforce the ban on smoking on school buses, and to condemn smoking on all forms of public transportation.

Prominent federation member Dr Blanche Bourgeois cautioned that too rigid a stand on tobacco and alcohol might be counterproductive and Home and School members ought to show youngsters that the measures sought are for their own good.

In other recent developments, a Saint John jury called for the drinking age to be raised to 21, after finding a teenager guilty of criminal negligence in the operation of a motor vehicle. A teenage girl died in the collision.

The Dalhousie Town Council passed a motion asking for the drinking age to revert to the 21 years which existed previous to the 1972 change in the Age of Majority Act.

During the spring session of the New Brunswick Legislature, Premier Richard Hatfield, whose government lowered the age, said the government would take a second look at the situation, but nothing further developed before the prorogation of the House in mid-June.

There is a degree of confusion in the New Brunswick situation, with 18 years the voting age for federal, provincial, municipal, and school board elections, and 19 the age of majority for all other purposes.

Prince Edward Island introduced a bill to raise the age this spring, but Premier Alex Campbell explained this was a device to debate the issue and helped to defeat the measure.

Tough laws unsuccessful in New York state

NEW YORK — Tough narcotics laws introduced in New York State four years ago have failed badly in reducing drug use and drug-related crime.

The results have been so negative that the study by the New York City Bar Association warns six others considering such legislation to reconsider.

The harsh laws, enacted with fanfare by then Governor Nelson Rockefeller in 1973, called for sentences of from 25 years to life for major traffickers, and indeterminate sentences of from eight years to life for those convicted of having more than one-eighth of an ounce of narcotics.

Minor drug violations were elevated to felony status and plea-bargaining was no longer allowed.

By mid-1976, the state had spent some $76 million in administering the law. This included the addition of some 40 judges to the bench.

The study has found that heroin use remains as widespread now as ever, and differs little from the situation in most other East Coast American cities. It says this negates any argument drug use would have grown worse without the law.

Again, as in nearby states, the rate of serious property crime normally associated with heroin use, rose steeply between 1973 and 1976. Felonious property crimes in New York rose an average of 15% and 14% in Pennsylvania, Maryland, and New Jersey.

Cash penalty may work for an alcoholic

HAMILTON — An alcoholic may blow $100 on a drinking binge, but a penalty of just a fraction of that may be enough to keep him complying with a treatment program.

In one study at Rutgers University, patients who didn't follow the treatment regimen had to forfeit $20 to their wives, which the women were to spend frivolously on anything they fancied.

A variation on the same theme is for the patient to deposit money with the therapist, and forfeit small amounts of it if he doesn't keep appointments or take disulfiram.

Edward M. Sellers, director of the clinical pharmacology division at the Addiction Research Foundation, told the second international symposium on compliance, held at McMaster University, that the money technique only works in limited situations: the patient must accept the bargain, and the therapist must have factors that he or she can manipulate. If there is no wife, for example, the $20 forfeiture obviously doesn't work.

Asked why these amounts of money will work, considering how much the average alcoholic is willing to spend on drink, Dr Sellers said only, "people will do incredible things for small amounts of money . . . isn't that true when you consider our income tax structure?"

Financial forfeits are only one facet of contingency management of alcoholism, which Dr Sellers says "appears to be among the most effective in managing behaviors associated with alcoholism, whether in a laboratory or a natural treatment setting."

There is a performance contract that leaves no doubt of what is expected, and what the consequences of failure are. Industry has used this approach with success rates as high as 70%, by making it clear to employees that they either get treatment or get fired.

Drinks by shot are vetoed

RALEIGH, NC — "Brown bagging" will have to continue in North Carolina as fundamentalist religious pressure has for the fifth time in eight years blocked moves to sell liquor by the drink.

North Carolina now remains the only state east of the Mississippi River that does not allow sale of single drinks.

More than half the counties have state-run stores, voted in by local option, which sell liquor by the bottle. Businessmen and civic boosters in urban areas have pressed for a change in the laws.

Those who drink in a restaurant or club will continue to carry liquor in a plain brown bag, and hide it under the table as they order ice and setups.

Canadian doctors deny bid to raise drinking age

By Betty Lou Lee

QUEBEC CITY — For the second consecutive year, the Canadian Medical Association has failed to endorse a resolution calling for a raising of the drinking age. The vote wasn't even close.

At last year's annual meeting, the motion called for 21 years. This year, the CMA board of directors recommended age 20 to the general council.

Two physicians who supported the motion drew from personal experiences. Dr W. A. J. Donald of Calgary said he had recently removed the spleen of a 15-year-old boy stabbed by another 15-year-old in a brawl when they were both drunk.

Dr Marcel Baltzan of Saskatoon said even though he was a hotel owner, he wanted the age raised because of his experience as a member of a hospital team that seeks kidneys for transplant.

"I know that the combination of youth, roads, and alcohol is a problem ... They kill themselves, and they kill others ... This has become a moralistic debate of older versus younger, but it's not a moral issue. It's a question of saving lives."

But Dr E. H. Baergen of Saskatoon said he wouldn't support such a motion until medical associations limited drinking at their receptions to two drinks in the first hour, and one in subsequent hours.

Most of the arguments against the motion were that it was unrealistic and that it discriminated against youth.

General council, the parliament of Canadian medicine, decided to call for a federal commission to study legislative attempts to control drinking and driving, and suggest alternatives.

The CMA council on community health called the problem "a serious public health hazard" and said the present approach is ineffectual.

The committee should have representation from the public, law enforcement agencies, the Canadian Bar Association, and the CMA.

The council also urged provincial medical associations to join provincial governments in promoting "an increase in the education programs regarding the dangers of alcohol."

A more specific recommendation from a joint committee of the CMA and the Canadian Bar Association was also endorsed. The federal minister of justice will be asked to amend the Criminal Code so police officers will have the power temporarily to take the licence of any driver whose ability to drive they suspect is affected by alcohol or other drugs.

In some jurisdictions, police already have the power to take the keys and/or licence of such a driver, without laying a charge. In some places, they also impound the car. The driver can get all three back when he or she is in better shape to drive, without charges being laid.

The association is also calling for a revision of the Divorce Act, which now has addiction as a grounds for divorce if the respondent has been "grossly addicted to alcohol or a narcotic" for at least three years and there is no reasonable expectation of rehabilitation.

It wants the word "grossly" deleted to give judges more discretion in such cases.

It suggests they conform in general to a definition of addiction along the lines of "a state characterized by an overwhelming desire, need, or compulsion to continue use of a drug; to obtain such drug by any means; for there to be present a tendency to increase the dosage; for there to be present a psychological and usually physiological dependence on its effects, and a detrimental effect on the individual and on society."

MDs warned of 'sophisticated' addicts

QUEBEC CITY — Canadian doctors are being warned not to be duped into prescribing a group of chemicals containing narcotics for drug-dependent patients.

In its annual report to the general council of the Canadian Medical Association, the council on community health says the Bureau of Dangerous Drugs is "extremely concerned over the extensive abuse" of oxycodone (Percodan), hydromorphone (Dilaudid), anileridine (Leritine), and hydrocodone (various anti-tussives).

Those dependent on these drugs can feign the right medical symptoms to convince doctors to prescribe them: migraine, headache, renal colic, and whiplash injury, for example. Another approach is to tell the doctor the drug is required to treat a narcotic drug dependency.

None of the drugs is recognized in the latter role, and should not be used as such, the council warns.

"Physicians are again urged to review their prescribing habits with these drugs, and to recognize the grave dangers of irresponsible, thoughtless, or ignorant prescribing of any drug which may produce dependency."

Dr J. E. Moriarity of Calgary, community health council chairman, said some addicts have become sophisticated enough in their abuse of such drugs to drink a whole bottle of a codeine-containing cough syrup, wait 15 minutes, and induce vomiting. They know in that time they have absorbed the codeine, and can get rid of the unwanted parts of the syrup.

FDA is at risk of a lawsuit in scheduling of pot: Cohen

LOS ANGELES — America's Food and Drug Administration runs the danger of being sued — probably successfully — for continuing to class marijuana as a drug of high potential for abuse.

This is the warning from Sidney Cohen, clinical professor of psychiatry at the University of California at Los Angeles, who has just retired after serving four years on the FDA's drug abuse research advisory committee.

He said in an interview with **The Journal** that at the last committee meeting "I told them I didn't think the present system of scheduling marijuana would stand up under a definition of high potential for abuse.

"I think that if somebody sues the FDA for falsely scheduling marijuana (it is now schedule one) they might well win. I don't think the FDA could prove high potential for abuse."

Dr Cohen said the answer lies in rescheduling some drugs.

"For example, there could be a schedule one A of drugs, which would be those with a high potential for abuse. There could be a schedule one B for drugs which have a lesser potential for abuse, such as marijuana.

"With such a schedule, one could be more flexible in letting drugs be used in research."

Dr Cohen made his comments to other committee members "for their own good. I think many of them are aware such a suit might be pending and they said the situation is under consideration."

He has carried out his own marijuana research at UCLA and found the system slow and cumbersome. At the same time, he realizes "it is a difficult problem.

"I found out once while doing my research that it involved some 11 agencies. This included the medical school, the country, state and federal groups, and agencies.

"All of these groups were looking at us and requesting information periodically. So it is a complicated matter in researching with schedule one drugs."

Dr Cohen has found it is difficult to know exactly what many officials at the FDA respond to. "If you want to understand the FDA, it is that if they are doing nothing, they can't be hurt. But, if they do something, then people can jump on them."

Some of the requirements now — for marijuana research "do seem onerous because it is on schedule one. However, there is a lot of marijuana research going on despite the difficulties."

Dr Cohen says one major need "is a program to start educating physicians about some of the dangers of drugs. They really don't know as much as they should. I would rather see education than prohibition."

For example, there have been calls to ban barbiturates, but he does not favor this. Certain ones have a clear medical use: "Phenobarbitol is inexpensive and does make a good anti-convulsant, and we have got to have them around for these reasons."

Sidney Cohen

Take leadership role, doctors urged

CMA wants clean air

QUEBEC CITY — The Canadian Medical Association will urge hospitals and doctors to assume a leadership role in discouraging smoking in patient treatment areas of hospitals.

But the CMA general council defeated, by 54 to 48, a motion calling for a ban on the sale of all tobacco in hospitals.

Doctors speaking against the motion said it would deprive volunteer associations of revenue and lead to blackmarkets in hospitals.

Dr Peter Banks of Victoria, a past president of CMA, said doctors shouldn't confuse their role: it is educational, not that of a police force.

Another physician said that when some volunteer-operated gift shops have discontinued sales of tobacco, cigarette vending machines have been installed right outside the shops.

FDA committee behind the times: Ungerleider

LOS ANGELES — Interminable delays because of strict controls are one of the major frustrations marijuana investigators face.

"It took me nearly 11 months of continuous activity before I could get to use marijuana in research," says Thomas Ungerleider, assistant professor of psychiatry at the University of California at Los Angeles.

"For that whole period I wasn't able to do almost anything else except correspondence, filling out forms, and acceding to demands.

"The demands, most of which were not very unreasonable, were still much more stringent than anything else, from morphine to demerol. It is very peculiar."

Dr Ungerleider is incensed particularly that marijuana remains on the Food and Drug Administration list of schedule one drugs, those with high potential for abuse.

"It is obvious to everyone that when it comes to abuse potential and therapeutic usefulness, particularly in glaucoma, marijuana in no way belongs to schedule one."

Dr Ungerleider believes the FDA's drug abuse research advisory committee must change its present policy.

When he has questioned the committee, he has been told rescheduling depends on pharmaceutical companies applying to manufacture commercially.

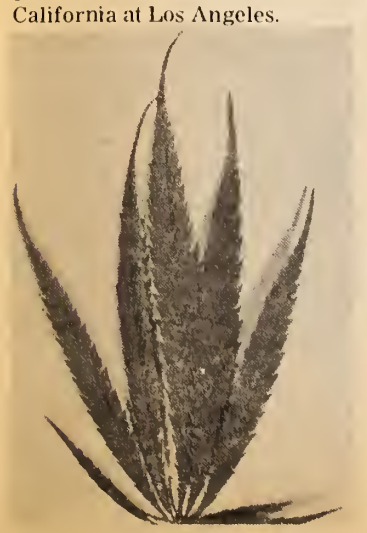
He says: "Rescheduling should have nothing to do with whether private industry wants to make money by marketing this drug."

Dr Ungerleider adds: "When they classify it with respect to the message it gives — LSD equals marijuana equals heroin — I think the committee is behind the times."

The reason he entered marijuana research in the first place was a promise to a dying friend that he would try and find out if the drug had usefulness in helping cancer patients.

Dr Ungerleider now wants to use marijuana on terminally-ill patients to control the nausea caused by chemotherapy.

"Believe me, I wouldn't do it ordinarily. You would have to be a masochist, otherwise, with all the forms and everything. The paper work just goes crazy."



Cannabis

Canada changes butorphanol listing

OTTAWA — The federal government has transferred the drug butorphanol, a man-made hallucinogen, from the Narcotic Control Act to the less stringent Food and Drugs Act after research showed the drug (and its salts) is not as addictive as previously thought.

The drug, one of a long list of products of man's chemical ingenuity in recent years, was originally put under Narcotic Control Act controls because it was believed to be highly addictive.

The chemical had been uncovered and synthesized by a Canadian firm doing research, according to health department officials.

The transfer to the Food and Drugs Act will bring the drug under import-export controls and prescription restrictions, the officials said.

The government scientists face a constant battle of trying to keep up with new man-made chemicals produced either intentionally or unintentionally in laboratories and used for non-medical, hallucinogenic applications.

US pot triers double

PRINCETON, NJ — One quarter of all Americans over age 18 say they have tried marijuana at least once, a Gallup poll has shown.

The figure is double what it was four years ago following a similar poll. The first Gallup survey in 1969 showed only 4% of adults had tried the drug.

More men (31%) than women (17%) have tried marijuana and more who have gone to college than who stopped at high school.

British brewers bottle better beer for jubilee

LONDON — Britain's heady celebrations of Queen Elizabeth's silver jubilee are being commemorated by many breweries, especially small ones, with special jubilee ales.

The ales are brewed to special recipes, matured longer than usual, and sport decorative bottle labels. In some cases ornamentation extends to the crown cap.

Because production costs are higher than normal, so are prices, which range from 25 pence to 35 pence (43-60 cents) a bottle.

But the beer lover gets his money's worth: alcoholic content of all the ales is markedly above normal and each has a distinctive taste.

None of the ales will be brewed beyond the end of the year.

Wadworth's, a small brewery in Devizes, Wiltshire, for example, has limited production of its Queen's Ale to 120,000 bottles. Not only does the ale bottle have a decorative label and silver foil around the neck, the front of the brewery building itself is decorated.

Whatever mystery has gone into the jubilee ales, a fortune is not to be had in buying bottles and holding them for 25 to 50 years.

Most collectors would have to be intrepid travellers because the ales are sold only in the region of the brewery. And a leading auction house, which has sold other old ales in the past, says the most they fetch is five pounds ($8.50) a bottle.

Most souvenir beer lovers just consider themselves doubly lucky — they can drink the beer and save the bottles.

Silver Jubilee Ale brewed by Courage's, one of the brewery giants, has a silver foil cap and a picture in silver of Buckingham Palace. In contrast, Donnington's a small brewery at Stow-on-the-Wold, atop the Cotswold Hills, uses a more simple label.

Mystique has always been part of the brewer's art, and two independent breweries which have benefited greatly from the real beer revival in Britain (The Journal, January) have gone all out: Harvey's, of Lewes, Sussex, and Young's of London.

Harvey's has produced for decades a strong tasting Elizabethan Ale. This year it has added the date and celebration to the label and made the ale even stronger.

Young's has brewed the highest alcoholic content ale of all — Silver Sovereign has a specific gravity of 1077, which, a spokesman explains, is to match the year '77.

It is sold at 25 pence: one penny a year to match Queen Elizabeth's reign. And it has been fermented for seven days because "tradition has it that a beer that takes less is an 'UnGodly Beer' as it has not been blessed by the Sabbath."

For young drug abusers

Pride House chips away the hurt and pain

By Harvey McConnell

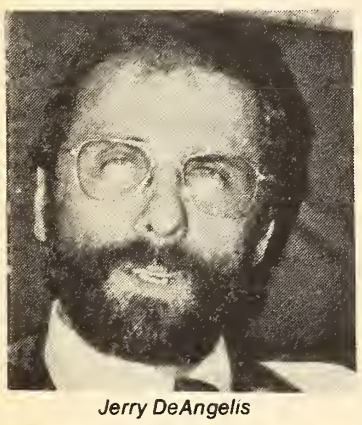
LOS ANGELES — Until six months ago, it was a convalescent home fronting semi-shabby North Sepulveda Boulevard and inside, it still looks that way — institutional, long grey corridors.

But the setting, enlivened by posters and blaring stereo, cannot dampen the family atmosphere among the 45 young people living at Pride House because of their drug problems.

Pride House is directed by Jerry DeAngelis, PhD, who made his first mark as a brilliant research chemist. He has no doubts: "I think categorically we are the best adolescent program there is.

"We try more and we do more. We take kids, including homosexuals, that most psychiatric hospitals won't even touch."

Dr DeAngelis has been willing to put himself on the line to back his concepts. Last year he signed a personal note for $800,000 and took a $75,000 loan on his house to pay for salaries and leases until grant money arrived via the state from the National Institute on Drug Abuse.



Jerry DeAngelis

At present, the non-profit Health Care Delivery Services, Inc, with a $1.4m budget, runs two methadone clinics, an outpatient detoxification centre, Pride House, the adolescent rehabilitation centres, and does research and evaluation as well.

The adolescent program is so successful that, by request, Dr DeAngelis is now considering starting a similar program in Nevada.

Dr DeAngelis points out: "We are not a drug treatment program with all the intimations. We are a health care delivery service program which happens to be offering that service to people who have trouble with drugs."

Unlike most other programs he knows, the Pride House program is not construction of a super-ego in the young people. "Our approach is very different in that we totally attempt to structure a healthy ego.

"We don't use confrontation, attack, manipulation by guilt. We tell the kids it is their life and they can do whatever they choose to do.

"There is no magic, and I think it is harder to do it that way."

Vast numbers of therapy sessions are agumented by awareness groups, seminars, school, and individual sessions with Dr DeAngelis. "We will spend months on a kid if we have to."

Above all, the young people receive the real missing links in their lives: love, care, and tenderness.

"What is really the saddest part is that when they come here they have never had it, and when you give it to them they don't want to believe it.

"Some of them run because they get frightened about it. Accepting tenderness is incredibly difficult, they don't trust for months and months and you have to be very careful."

The young women "are so deprived that just to have someone treat them politely is a victory. The whole women's movement is very foreign to them, but we treat the kids equally, and maybe it will become ingrained."

It is a long struggle for the young people to realize the love is unconditional, "that we love them whether they are doing well or messing up absolutely, Dr DeAngelis continues.

"We tell them their behavior at times may be stupid but they are not stupid people. That is the hardest thing for them to learn."

Pride House is a long jump for the biochemist doctorate who joined Pfizer as a researcher and who currently holds five patents for bronchodilator and cardiovascular drugs.

Research after three years proved a bore and Dr DeAngelis persuaded the pharmaceutical company to set up a further education program for doctors. Along with cardiovascular disease and diabetes, in 1970 drug abuse gained new ground among most doctors.

Dr DeAngelis organized a New York meeting on drug abuse for 300 doctors and 3,600 showed up. This led eventually to workshops around the country, contact with experts, and two years in Washington with the Special Action Office for Drug Abuse Prevention.

He joined the department of psychiatry at the University of California at Los Angeles in 1973 and last year, in effect, took over the programs UCLA had initiated.

Associate director is Eddie Ross, a heroin user for 15 years until in 1971 "I just got tired and stopped."

Mr Ross understands especially the pressures that can be put on young people. He came from a well-to-do family, was not deprived, but started on drugs through peer pressure.

"Most of the kids who come here have seen only poverty and crime, and generally have not even eaten healthy food. With us, it is like a family and they know they can always come back."

Dr DeAngelis and Mr Ross are extremely encouraged that in seven months the young people have settled down in the former convalescent home.

The first Pride House was small and homey but bursting at the seams and had a huge waiting list. This prompted Dr DeAngelis to take a gamble, in more ways than one, to move.

Now the intake has been expanded and the atmosphere improves daily, Dr DeAngelis says.

Pride House has allowed Dr DeAngelis to hone the concepts he first formed seven years ago in Connecticut when he acted as voluntary consultant to a day care and residential facility.

"I thought when I moved here we'd have opportunities to explore different kinds of therapeutic approachs for kids.

"We spend a great deal of time understanding the underlying dynamics and couple this with concepts of being totally supportive. We try to help the young people to understand they have a right to live a life that is unlike the one they lived before.

"We hope they separate in a healthy way, and that like a good family they can always come back to cry or ask for advice."

In the near future, it is hoped enough money can be found to open half-way houses so many of the young people can live freely under loose adult supervision.

Like any good family, Pride House has its rules and regulations.

Dr DeAngelis says: "We do an awful lot of boundary definition and limit setting. And one of the hardest things is to teach the counsellors to be consistent: if they set a limit on Monday it better be the same every other day of the week."

Although the director is called Jerry, the pater familias role comes naturally. "When I walk down the hall everyone snaps to attention.

"I grew up in the East and the kids know that there is a part of me that if they mess around I can give them down home with the best of them."

The young people know also that twice a week Dr DeAngelis dons jeans and T-shirt to play basketball or volleyball with them, "and allow ourselves to be human.

"On the basketball court, for example, all is fair. On a rebound they might get me in the stomach. Cool.

"But they know they better watch me the next time they go up for the ball."

Dr DeAngelis has no self-delusions about his role and his abilities. He explains:

"When I started seven years ago, and for the first couple or three years, it was great to know that I could really be this wonderful therapist.

"Now, at this point in my life, I have had too many failures to think that I really have that much power. I have had kids with whom I have felt I had just had the greatest session ever, and I turn around and they have packed their bags and left.

"So I am no longer into the omnipotent bag."

Even today, "I don't know what works. I think what makes us very different is that we are constantly willing, and totally willing, to be supportive, to care, no matter what the behavior is."

"Michelangelo is one of my favorite artisans and artists, and I do a lot of painting myself.

"I am always amazed that he really felt, when he took a block of marble down from Carrera, that the statue, the Pieta for instance, was there. He just chipped away the excess.

"My philosophy here is that underneath all the kids come here with, our job is to simply chip away and peel away the hurt and pain and out will come a pretty healthy kid."

Eddie Ross

FDA bans 'daytime use' labelling

WASHINGTON — A ban on sedatives which are labelled for daytime use will be made by the United States Food and Drug Administration.

FDA Commissioner Donald Kennedy, in announcing the proposed ban, said people who use them run the risk of becoming drowsy when they may be operating cars or machinery.

"Given this risk, and the absence of any demonstrable medical benefit, there seems to be no justification for the continued marketing of these products," he told a Senate subcommittee.

The proposal does not mean the sedatives will have to be withdrawn from the market, but it will force a change in labelling and advertising.

Dr Kennedy said there is no evidence the "daytime sedatives" lessen anxiety or provide any medical benefit.

At the same time, he said he has asked the National Cancer Institute here to speed up studies to see if methapyrilene — a major ingredient in most sedatives — is a cancer risk.

Women surpass men in tobacco use: study

TORONTO — Female students in Ontario are more likely to be tobacco users than their male classmates.

A survey of alcohol and drug use among Ontario students has revealed that, for the first time, tobacco use is slightly higher among females than males. Questionnaires from 5,862 students at 104 schools indicated that 32.1% of the female respondents had used tobacco at least once in the previous year compared to 28.5% of the male students.

Reginald G. Smart and Michael S. Goodstadt, from the evaluation studies department of the Addiction Research Foundation of Ontario, note that earlier studies of Toronto students showed an increased level of female smoking, but females had always been less likely to smoke than males. The present results also differ from those in a 1976 national study by Health and Welfare Canada which showed male smokers outnumbering females, they said.

In the current study, although the percentage of female students who smoked was greater than the percentage of males, males who were smokers reported smoking more than the females.

Overall, Drs Smart and Goodstadt said the February 1977 survey showed that changes in drug use since 1974 — when a survey of Toronto students was conducted — have been small, and increases have been confined to a few drugs such as alcohol, cannabis, and LSD.

Responses from students in grades 7, 9, 11, and 13, revealed that alcohol was used by most students (81.9%) at least once in the previous year. The next most popular drugs were tobacco and cannabis, used by 48.6% and 25.1% of the students, respectively.

Users of most drugs used them infrequently in the previous year. The majority of users of glue, solvents, heroin, speed, psychoactive drugs, and illicit drugs reported using them once or twice.

Reginald Smart

However, alcohol was drunk at least once a week or more by 17.9% of all students, and cannabis was used 10 or more times by 11.9% of all students. About 22.7% of all students smoked at least one tobacco cigarette per day. About 16% of all students (23% of drinkers or 30% of past-month drinkers) had been drunk and 23% (32% of drinkers or 39% of past-month drinkers) had had at least five drinks on some occasion in the preceding month.

The Toronto researchers also found student drug use was significantly related to age, with most frequent drug use occurring generally among 16- and 17-year-olds. Reported alcohol use varied from 57.1% of students under 12 years of age to 94.8% of those aged 18 or over. The proportions for tobacco use ranged from 5.5% of those under 12 years of age to 42.5% of those aged 16 and 17. Only 5.9% of those aged 12 to 13 but 42.5% of those 18 and over had used cannabis in the preceding 12 months.

The use of LSD and other hallucinogens was also found to increase with age, but use of heroin, speed, and cocaine did not vary significantly across age groups.

Although females more often than males reported use of tobacco, males more often reported use of alcohol, cannabis, glue, speed, cocaine, LSD, and other hallucinogens. Similarly more males used cannabis and alcohol more often than females.

The researchers also found a significant inverse relationship between drug use and grade average. For example, 12.1% of students with the highest grade average but 40.2% of those with the lowest reported cannabis use. For all drugs the frequency of reported use was greatest among students with a grade average below 60. More students with low rather than high averages drank alcohol at least once a week, reported wine drinking at family meals, having been tight or drunk or reported having had at least five drinks on some occasion in the previous month.

Relationships between drug use and parents' occupations were few, but cannabis was found to be more frequently used by students of professional parents.

The researchers also found some regional variations in drug use. Students in the Northern region of Ontario more often reported the use of alcohol, tobacco, cannabis, LSD and other hallucinogens, non-prescription barbiturates, and non-prescription tranquillizers. Use of non-prescription stimulants was highest in the Niagara region and the Ottawa valley.

The Midwestern region of the province was lowest in reported use of tobacco, alcohol, cannabis, non-prescription barbiturates, speed, non-prescription stimulants, LSD, and other hallucinogens. Use of glue, heroin, cocaine, and prescribed psychoactives did not differ across regions.

Do as we say smoky board tells hospital

WINNIPEG — A resolution to ban smoking in the Health Sciences Centre, Winnipeg's largest health establishment, was recently passed by its board of directors.

They also banned the sale of tobacco products in the centre.

The directors made two exceptions: certain staff lounges will be smoking areas, and the directors themselves will be able to smoke at board meetings.

Increased cocaine use might spell big trouble

(from page 1)

buy and people do not use it in large quantities. It is not known, however, what would happen if it became very much cheaper, very much more widely abused, and used more chronically and in much larger quantities.

"It is only speculation but there is a strong suspicion that the death rate and other health consequences would be substantially greater if cocaine were much cheaper and more available," Dr Bourne said.

Meanwhile, the effects of drug trafficking in Latin American countries are alarming, he said.

Columbia is estimated to be earning more money now — some $500 million a year — from drug trafficking than from coffee, and in hard currency. Farmers are pulling out coffee trees to grow coca plants and marijuana.

"The Columbia economy is becoming increasingly a drug based economy," said Dr Bourne.

Although the US has agreed to supply Columbia with three helicopters and other equipment worth $3.7 million to fight the drug traffic, "I'm not even sure in this instance with the most sincere cooperation, if it is really going to deal with the problem very effectively," Dr Bourne said.

The idea of introducing any sort of crop substitution for the coca plant "looks totally impractical".

As for heroin, cooperation with the Mexican government in the eradication of a significant percentage of the opium crop earlier this year, has resulted in the purity of street heroin being at its lowest level since 1973.

"It is clear there is less total heroin coming in than in quite some time," Dr Bourne added.

Cooperation with the governments of Burma and Thailand has now reached a new level. "I think this has to do with the development in part, of severe heroin problems in these two countries and it is not altruism alone that has led them to be concerned about heroin," he continued.

The US is working "with less success" with Afghanistan and Pakistan, but Dr Bourne believes the situation in dealing with the opium problem there is improving.

In global terms "the situation is one where the prospects of ever eliminating opium cultivation are pretty remote. I think we have to see the situation as a constant battle, almost like a chess game, trying to stay ahead of your opponent and keeping him off guard to try and minimize the flow of drugs to this country."

Dealing with domestic issues, Dr Bourne said "the single most important thing we are trying to do in national policy is reducing the mortality and morbidity relating to drugs and placing our resources according to those drugs which provide the greatest threat.

"We also have to be as realistic as we can be with limited resources. The days are gone when we are going to have large amounts of money to spend and we are trying to look very carefully at what we can do that will have some kind of payoff."

Values guide social reaction to drugs

(from page 1)

drug taking behavior and how society responds to it have "a great deal more to do with values than they do with science, and a great deal more to do with politics and religion than with the biochemistry and the sociology."

The goal should not be making a distinction between the use and abuse of drugs, it should be the reduction in the use of all recreational drugs.

"The search for a safer drug is an illusionary kind of effort. Those forces in society, and they are many, who are attempting to reduce drug use, clearly need to be supported."

Making marijuana legal will unquestionably increase its use in society. Dr DuPont said he is prepared to put up with the present illegal activity "and all the negative effects of it but I don't put up with it comfortably. It is just that the alternatives seem worse to me."

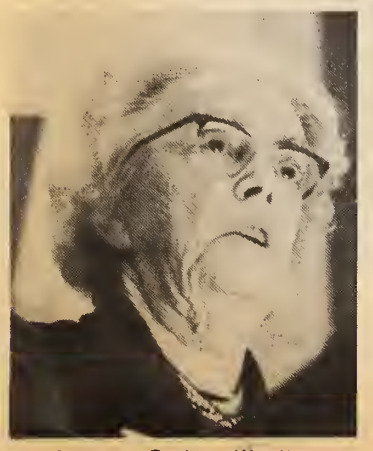
Dr DuPont said: "We are in for a long, long, long, hard road with respect to a lot of drugs. I think marijuana is the leading edge of a whole new wave of drugs adding on to alcohol and tobacco, which we have a long history of problems with, and we are just beginning to understand how much of a problem we have."

UK pot use cuts across class, race, and age

(from page 1)

casting Corporation put the figure closer to four million.

"Whatever the real number is," comments Release, the often controversial British organization concerned with drug addiction, "it is clear that the use of cannabis is no longer restricted to any particular class, race, or age group, and that it has, indeed, become a functional equivalent of alcohol for a large number of people regardless of the law's moral posture."



Baroness Barbara Wootton

One frequently recurring view expressed by specialists in public discussions here is that, while cannabis can be abused, it is far less dangerous than tobacco or alcohol and its connection with hard drugs may only come about because both are illegal.

Indeed, the eminently respectable Lord Boothby recently told Parliament amidst laughter: "I have smoked cannabis . . . I have also smoked cigarettes and drunk alcohol. There is a greater argument for prohibiting alcohol consumption and cigarette smoking than there is for cannabis — but I shall continue to smoke heavily and to drink heavily."

It is not clear what penalties the administration will set for possession of cannabis in its promised amendment to the Criminal Law Bill. In all probability, they will still be considerably stiffer than in Mississippi (the last American state to legalize alcohol consumption) which has just decriminalized cannabis and set a maximum penalty of $100 fine for possession.

Penalties in Britain are defined under the Misuse of Drugs Act which recognizes three classifications, ranging in seriousness from Class A which groups hard drugs such as heroin, to Class C covering drugs like amphetamines. Cannabis is at present in Class B. The advisory council may either recommend the rescheduling of cannabis as a Class C drug or the creation of a special, fourth category for it. A review may also bring about further changes in the classifications, including perhaps the control of barbiturates.

The review will also eliminate a judicial contradiction which has made the law, in the view of the advisory council, "confused, unsatisfactory and possibly unworkable."

The Court of Appeal has ruled that a person cannot be convicted of possessing cannabis if he was found to have only the leaves and stalk of the plant, even though they contain the active ingredients of cannabis derivates which are listed as Class A drugs and their possession is subject to higher penalties than that of cannabis. The definition of cannabis under the law will therefore be changed from the present "flowering or fruiting tops" to cover the entire plant.

Several speakers during a recent House of Lords debate appealed for decriminalization of cannabis to save the future of many thousands of young people who are likely to be found in possession. They followed the reasoning of Mexico's law makers who, until recently, considered cannabis as a drug as dangerous as heroin and other narcotics, and who have just announced the release of about 2,000 people, many of them Britons and North Americans, found in possession of small quantities of cannabis.

"The majority of them are youths who would be tremendously damaged in jail," explained a spokesman for the Mexican attorney-general's office. He added that the full rigour of the law, involving up to 15 years' imprisonment, would continue to be applied to hard drug offenders.

CA cuts down crime area liquor shops

SACRAMENTO — California law officials believe it is unhealthy to have a high concentration of liquor outlets in urban high crime areas.

And the director of Alcohol Beverage Control has suggested that cutting the number of new liquor licences would be a step in the right direction, because "we have a constitutional obligation to public welfare and morals."

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Letters to the Editor

Smokers' time up

This letter is in response to Stan Sadava's (**The Journal**, June 1). Mr Sadava objected to what he views as unfair restrictions on the smoker by such public health pressure groups as GASP (Group Against Smokers' Pollution) and called for 'compromise' and 'courtesy', instead of non-smokers imposing their right to breathe clean air on smokers.

Now he knows what non-smokers have, for generations, experienced in a society in which smokers always seemed to have all the rights (although only 45% of adults actually smoked). It is interesting that suddenly there are cries from the smoking camp for 'compromise' and 'courtesy' when, until the advent of the non-smokers' rights movement, most smokers evidenced scant concern for these concepts.

This movement should not have been necessary, but it is, and it is growing across North America and the world. Along with it, is growing public awareness that non-smokers have rights too. This comes, unfortunately, as a rude awakening to many of those with a tobacco dependency problem. For this problem, they have our sympathy. But it is hardly fair to ask that we suffer with them!

Margo Redmond
Wisconsin Association on Alcoholism and Other Drug Abuse Inc
Madison, Wisconsin

Stamps approved

I want to compliment you on your feature article *Stamps carry messages in miniature to millions* (**The Journal**, June).

I am using the article in my exhibit for our national WCTU convention this year, which is combined with our World WCTU postmark for our triennial convention in Australia. Several of our Canadian members will also be attending.

Marian B. S. Crymes
Washington correspondent
National WCTU
Washington, DC

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Inside Science

Problem drinking: precise de

By Reginald G. Smart

Much of the interest in the drinking problems of young people has been created by the reduction of the legal drinking ages in many American states and Canadian provinces.

Unfortunately, it is not easy to define a "drinking problem", or misuse of alcohol, or alcoholism, for any population, young people included. These terms involve vague concepts and value judgements with meaning only within the context of a single study. Currently, we have been considering the kinds of definitions for these terms and we have conducted two studies of youthful drinking problems in Ontario. What definition is employed has a large effect on the results of studies of problem drinking. A narrow or strict definition will turn up few problem drinkers and a more liberal one will turn up far more.

Typically, "problem drinking" scales have been based either on Jellinek's drinking phases or on Straus and Bacon's college drinking studies of the early 1950s. They developed scales of social complications, warning signs about problem drinking, and anxiety about problem drinking. As expected, all were somewhat related.

The social complications scale included questions about how drinking had affected performance in various tasks, i.e. drinking with "social damage". The questions included items about failure to meet obligations (e.g. studying for examinations or missing an appointment), loss of friends, accident or injury, and formal punishment or discipline. They were scaled in order of seriousness, so that anyone who had had formal punishment for drinking consequences had probably experienced the others as well. About 65% of men and 85% of women experienced no complications and most experienced only failure to meet obligations.

Straus and Bacon also asked about four warning signs of problem drinking (blackouts, becoming drunk alone, drinking before or instead of breakfast, and participating when drinking in aggressive or destructive behavior). Of the male drinkers, 60% did not experience any warning signs, 22% reported one (usually blackouts or getting drunk alone), 8% reported two, and 5% three or four. Of women, 94% reported none, 5% one and 1% two or more. In the early 1950s, about 6% of college men and about 1% of college women had drinking problems. Later studies have refined and improved the Straus and Bacon scales.

Many of the largest surveys of high school drinking do not enquire about problem drinking. Only a few studies have produced data for high school students.

We examined the nature and extent of drinking problems among high school students in two separate studies. One study was made of 1,439 students at two high schools in Orillia, Ontario. In it the quantity-frequency index, problem-drinking symptoms, and social complications from drinking scales were used. Also, students were asked how often they had become "high", "tight", "drunk" and sick from drinking in the past four weeks.

More than half of the students who

Backgrounder

West's heroin problem pales beside Asia's

By Tony Garnier*

WELLINGTON, NZ — The domino theory is still thriving in South East Asia, despite the ending of the Vietnam war.

But it is no longer used to explain the fall of one country after another as the so-called "yellow peril" supposedly overran the region.

Rather, it is now being used to describe a rapidly spreading tangle of personal misery, family and social upheaval, subversion, corruption, and "greed" sweeping the region through the use of heroin. All strata of society, business, the government service, and schools, have been affected.

A Northern Thai child

The scale of the problem in countries like Thailand, Malaysia, and Singapore, makes the far more publicized abuse of heroin in Europe, Canada, and even the New York area of the United States pale by comparison.

Statistics clearly reflect the rapid and recent rise in heroin use in South East Asia.

Five years ago, heroin was mainly a drug that was shipped southward along the Malaysian pan handle to Singapore and on to Europe and the US from the "golden triangle" of Burma, Laos, and Thailand.

In 1972, four people were arrested in Singapore for suspected heroin offences. This increased to 10 in 1973 and 110 in 1974. In 1975, it jumped to 2,263 and in the first six months of last year, 2,284 people were arrested for suspected heroin offences.

There are an estimated 8,000 heroin addicts in Singapore, mainly aged between 14 and 25 years and "hooked" in the last two years. Singapore has a population of 2.2 million.

Malaysia's problem appears much worse. Authorities claim that of its 12 million people, 150,000 are heroin addicts. Newspapers have recently been giving massive coverage to drugs, and question time in parliament is dominated by the topic.

Police and a recently-formed Malaysian narcotics squad are particularly active. In the last half of 1976, police conducted 250 drug raids, detained 2,500 addicts, and seized about 10 lbs of heroin. In the past 18 months, police "busted" 15 drug pushing syndicates, and cracked three international syndicates using Malaysia as a distribution area for the world market.

A United Nations survey indicates that about 50,000 lbs of heroin is annually being trafficked into Malaysia from Thailand. Clearly, the police are merely scratching the surface of the problem.

At the level of rehabilitation of addicts, Malaysia has some massive problems to overcome.In recognition of the scale of the task ahead, the government last year established a Cabinet sub-committee under the Deputy Prime Minister. The decision followed revelations in a Malaysian University survey among secondary schools.

The survey showed that 12% of the 16,166 pupils interviewed admitted using heroin. For every pupil that admitted using the drug, another five expressed interest in trying it. In one sample from Penang, considered one of the worst affected areas, of 1,500 interviewed, 238 said that they had used heroin, compared with 288 who admitted to smoking cigarettes.

Other statistics indicate that 120 government servants are presently undergoing drug rehabilitation. There are reports that police (especially in the lower ranks) and armed forces personnel have been addicted to heroin. Thailand officials are convinced that about 12% of the country's 60 million people are addicted.

The drug problem has been in the region for years, but until seven years ago it was mainly thought of in terms of elderly Chinese smoking opium in the many dens found in urban areas.

Then in 1969, doctors in both Singapore and Malaysia publicly warned of increasing heroin use among young people. At the time, the doctors were reported to be "alarmists."

Authorities in both countries now agree they are facing a problem of epidemic-like proportions. They are especially concerned about the political implications.

Singapore's minister of home affairs and education, Chua Sian Chin, claims there are indications of a communist plan to use narcotics to corrupt and soften the people of the various states in the region for the purposes of subversion and eventual takeover.

In fact, he says this happened in South Vietnam, and was a major factor in its eventual collapse. "Drug addiction became rampant and uncontrollable. It not only sapped the spirit of the soldiers to fight but also undermined their fitness. Thus, from the very onset, they had no chance at all despite their superiority in fire power, military hardware, and sophisticated gadgetry."

Malaysia's law minister, Tan Sri Kadir, relates his country's present drug problem directly to the Vietnam war.

In 1968, United States troops fighting in Vietnam began visiting Malaysia for "rest and recreation. They brought a taste for drugs with them and it spread to the locals," he said.

It soon became the "in" thing for local Malaysians to copy the Americans in terms of their dress, manners, films, music, and drugs. Now the drug problem hits all socio-economic groups.

Mr Tan believes drugs by themselves won't bring down Malaysia. But he is convinced drug use is a significant factor in present subversive disturbances and, especially, in a rash of large bank robberies occurring daily.

The major reason for large quantities of heroin being pushed, and underlying the political subversion and exploitation of the young, is the profit motive. In this context, South East Asia's drug problem is being fueled for gain by both communist and capitalist elements.

There is clearly widespread concern that South East Asia is still regarded by the superpowers as an arena for big-power conflict, with heroin as one of the weapons.

** This is the first in a series of articles by Tony Garnier, political correspondent for The Evening Post newspaper in Wellington, New Zealand. He was awarded the 1976 New Zealand Mobil Overseas Travel Award to travel around the world for four months to study political, social, and personal aspects of the drug problem.*

finition is all-important

were drinkers became high at least once, 42% drunk, 13% ill, but only 6% passed out. However, 5.8% became drunk five or more times, and 3.9% four times in the past four weeks. It seems entirely arbitrary what frequency of heavy drunkenness is chosen as "misuse" or "problem" drinking.

The Problem Drinking Scale is not much more helpful. Scores ranged from 0 to 7, with no convincing reason for any cutting point above 0. If a score of one or more is taken, then 59% of high school drinkers are included; if three to seven then 28%, if six or seven then only 2.1%. This study could provide evidence for either a very low or a very high rate of problem drinking or drinking with damage among high school students.

A second study has recently been made of some 4,687 students in grades seven to 13 in Ontario. This study involved a random sample of students from all areas of Ontario, 20 school boards and 104 schools. It should give a reasonably good representation of the students in grades seven to 13.

A four item alcohol problem scale was devised involving questions about: (i) being arrested or warned by police because of drinking; (ii) consulting a doctor or school counsellor or having been in hospital because of drinking; (iii) wishing that they could drink less; and (iv) having parents who think that they drink too often.

About 14.5% of drinking students reported a score of 1 or more on this scale. Of those, 11.9% reported only one item, 2.3% two items, .33% three or four items. The results are very different from those using the Park Scale which is longer and has different items.

In conclusion:

(i) many studies of youthful problem drinking have used some sort of "problem" or "social complications" scale. Just what scale scores should be taken as cut-off points between normal and "problem drinking" or "alcohol misuse" are arbitrary.

(ii) the range of young persons defined as "problem drinkers" may range from less than 1% to 50% depending upon the decisions taken about the definition of normal and abnormal drinking.

(iii) we need to be very careful in reporting and interpreting rates of "problem" drinking among young people.

* * *

Dr Smart is associate research director (evaluation studies department) of the Addiction Research Foundation of Ontario.

Comment

Has public been misled?

By Harvey McConnell

Robert DuPont is right (page 1). But is he too late? The wheel may be turning full circle around marijuana for some but certainly not for the majority.

As Dr DuPont told his audience at Cambridge, science and the law have created a cleft stick. "A scientific concern with the issues in the marijuana field has tended to promote marijuana or at least to be very permissive with respect to marijuana use." And "the move toward decriminalization is, in fact, interpreted widely by the public as a move towards permissiveness with respect to marijuana."

There is no question a decade or so ago much of the propaganda aimed at stopping young people from using marijuana was exaggerated, and in some cases dishonest intellectually.

But, in the scurry to disprove the harmful things attributed to marijuana and to try and see if it did have a use — as a legitimate and honorable scientific aid — the scientists, as Dr DuPont recognizes, have given a misleading impression. The same thing has happened with the law.

As long as marijuana use was confined to blacks, hispanics and musicians, few cared how many went to jail and for how long. When middle class children began being arrested, however, the movement to change the law began.

The scientific interest and the pragmatic interest in keeping people out of jail has fostered the image of marijuana use as an innocuous pastime. Because use of the drug has now become so widespread, the logic of decriminalization is obvious.

However, without question, marijuana users in particular and probably a majority in general, would declare that the drug is less harmful than alcohol or cigarettes. A meaningless comparison.

It is only in the past 15 years that the link between cigarette smoking and lung cancer has been proven, to most epidemiologists, and certainly a significant percentage of the male population in North America and Northern Europe has stopped smoking.

And it was not too long ago the "evils of drink", temperance movements, or even those who advocated moderation were good for hoots of laughter, and the drunk was a loveable character. Who laughs now about alcohol?

As the legitimate scientific concern, and the move to change the law, have clouded the reality of marijuana, another mistake may well be in the making. This is the lumping together of alcohol, tobacco, marijuana, and cocaine as "recreational drugs." If you drink and smoke, why not have a joint and a snort?

Recreation equals fun and enjoyment: golf, tennis, sailing. Or it use to. Now add drugs.

But what is "recreational" about drunk drivers and the thousands they kill on the roads each year? There is no recreation, literally, for the smoker sputtering with his emphysema.

As the **The Journal** has reported in the past few months, the "recreational" combination of marijuana and alcohol by many young people has produced some potentially lethal situations. Cocaine users, because they have the money, have become severely psychologically addicted. Recreation?

As mistakes were made with marijuana, the same mistakes may not be made with cocaine.

Dr Peter Bourne, White House advisor on drug matters, at the same conference as Dr DuPont, posed the question that if cocaine is entering the United States in large quantities, and is not a serious health hazard, does anything have to be done about it?

Yes. There is a "strong suspicion the death rate and other health consequences would be substantially greater if cocaine (becomes) much cheaper and more available."

It is not only the "recreational drugs" that should be of serious concern. Tranquillizers are the most prescribed drugs in the world and while cloaked in a "medical" label, how many millions are doled out to patients for a real medical need?

North America is now a drug-conscious and drug-using society, and the future offers little hope of major change. But efforts must be made at least to hold back continued increasing drug use and perhaps even reduce it.

After all it was only a short time ago that the hallmark of security was to say something was "as safe as aspirin."

Mr McConnell is a contributing editor to The Journal, and is based in Washington, DC.

English breweries join fight to foil under-age drinkers

LONDON — Britain's brewers are showing increasing concern about the rising incidence of problem drinking among young people.

With the cooperation of the licensed trade, they are distributing two million "yellow cards" to more than 70,000 pubs, designed to remind young people that it is illegal to purchase or consume intoxicating liquor on licensed premises.

The yellow card is the traditional "warning" of referees in the national game in these islands, soccer.

The scheme has been devised by the Brewers' Society*, the National Union of Licensed Victuallers, and the National Association of Licensed House Managers, and is supported by the Scottish Licensed Trade Association.

A spokesman for the society told **The Journal**: "It aims to get through to youngsters in a friendly way in terms they can understand and accept.

"The message clearly establishes the licensee's authoritative position in the public house and points out that his duties in ensuring the laws are obeyed are similar to those of a referee in sport."

The yellow cards will be supported by striking black and yellow bar posters and door stickers also setting out the "Under 18' rule. Beside the picture of a referee holding a yellow card is the clear message:

"The law says people under 18 must not drink or purchase alcohol in this bar." Licensees are also being sent a detailed four-page leaflet guiding them on the law as it concerns children and young people.

John King, president of the National Union of Licensed Victuallers, said: "No licensee wants under-age drinkers in his pub. The under 18 rule campaign is designed to prevent offences and to help youngsters understand how important it is for the pub to remain the place for moderate, sensible drinking and not to be abused by the mindless minority. Other outlets where youngsters can get drink more easily should also make the ban more effective."

Harry Shindler, general secretary of the National Association of Licensed House Managers, said: "Public house managers welcome this step to reinforce their authority in the pub. Millions of people enjoy their drink in harmless moderation — but there is a growing tendency for kids who look older than they are to upset the congeniality of the pub atmosphere by drinking too much. This has to be curbed for the youngsters' sake and also to ensure that the pub remains the cornerstone of social life for the majority of the population.

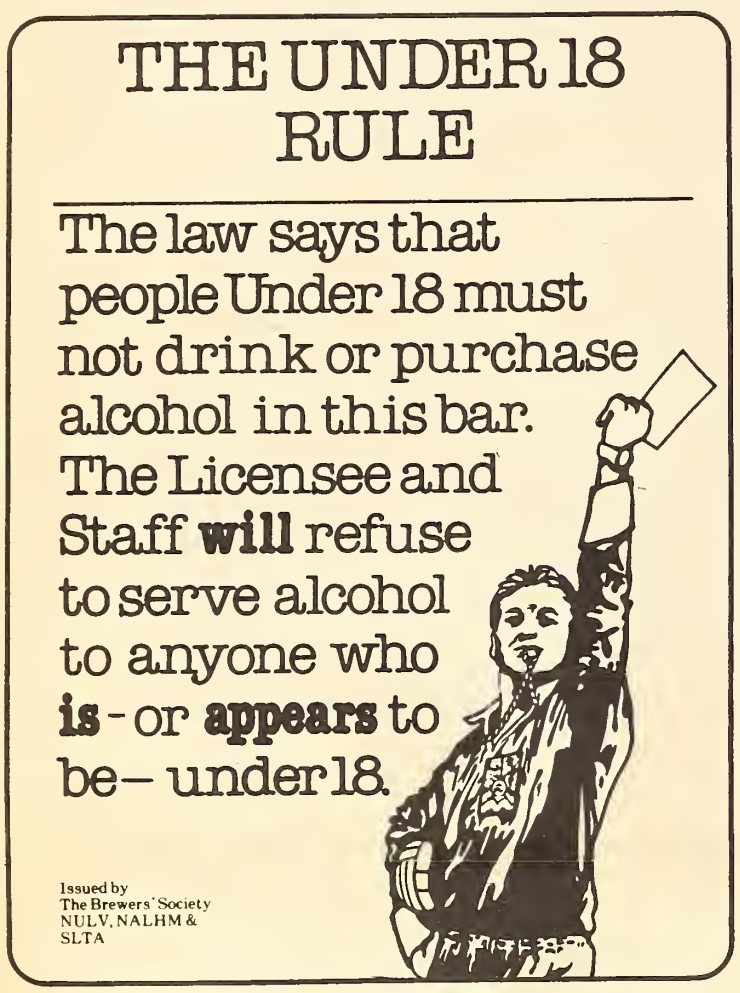
The under 18 campaign is the second time British brewers here have shown their concern about drinking among young people.

Earlier this year, they devised an educational project for use in secondary schools about the dangers of alcohol abuse. Based on a teenage comic called "It's Your Round," it is accompanied by a set of teachers' notes which enable group discussions to develop between pupils. Thus, the youngsters are encouraged to think for themselves. The educational material was distributed to every secondary school in Britain with funds provided by the brewing industry.

Derek Rutherford, director of the National Council on Alcoholism said: "One welcomes the initiative of the licensing trade to look at this problem because there is a rising trend in under-age drinking which is leading to increased drunkenness. I think the licensing trade in the past has come in for criticism and therefore this should allay the fears of youth leaders and teachers who have expressed the view that the publican doesn't care. The Brewers' Society should be congratulated on their initiative."

* **Brewers' Society, 42, Portman Square, London W1H OBB, England.**

Illustration: 'It's your round.'



Posters now appear in British pubs.

Kiwi alcohol costs are high

WELLINGTON, NZ — Alcohol problems cost each New Zealand citizen at least $130 a year in consumer costs and taxes, according to the National Society on Alcoholism and Drug Dependence.

This estimate was given to the Summer School on Alcohol Studies by the society's president, Roy H. Johnston, who added the estimate was conservative.

He said 86% of New Zealanders aged 18 and over use alcohol. Of these, 7% consume 40% of the total daily intake of pure ethyl alcohol. Of a total population of 3.1 million, 120,000 drink to hazardous levels (more than 10 centilitres of pure alcohol a day) and 53,000 are addicted to alcohol.

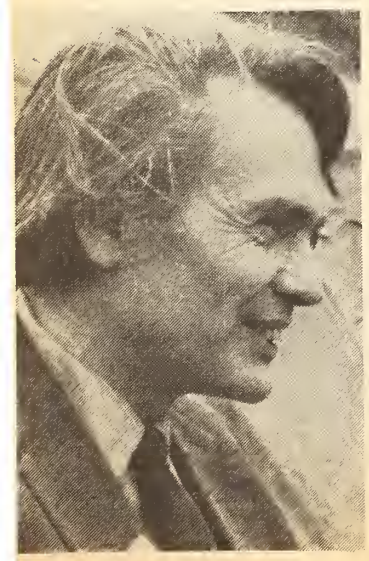
Between 1970 and 1975, alcohol consumption in terms of pure alcohol per capita rose in New Zealand from 8.26 litres to 11.36 litres. Mr Johnston said the price of alcohol in relation to disposable income — "the sole means of controlling overall consumption" — is small by international comparisons.

The society's assessment, supported by overseas studies, is that 60,000 workers (5% of the 1.22 million people in the work force) are affected by alcohol problems.

Applying a conservative estimate from a study of 18 major corporations by the United States National Council on Alcoholism gives a total cost to New Zealand industry of nearly $100 million a year — a cost met by the consumer with every purchase of goods or services, Mr Johnston said.

By occupying 26% of hospital beds, causing motor accidents, and using various state and voluntary services, people with alcohol problems cost taxpayers another $300 million a year, he added.

Self-treatment as good as complicated care?



Griffith Edwards

LONDON — Expensive treatment programs for male alcoholics may be unwarranted.

A team of British doctors has found that a "do it yourself" program for married male alcoholics achieved almost identical results to those obtained through a typical alcoholism rehabilitation program.

Drs Griffith Edwards and Jim Orford, of the Family Alcoholism Clinic at the London Institute of Psychiatry, say the do it yourself program is a low-key, money-saving way to treat married male alcoholics. They claim it works as well as expensive treatments including those involving admission to rehabilitation facilities.

The investigators described their study in a recent issue of the Journal of Studies on Alcohol.

In the do it yourself program, alcoholics are simply told they have a huge problem, given advice, and told the outcome is in their hands. Then they are put on their own and told to report back a year later. No medication is given to the patients. The alcoholics' wives, who are present for the advice session, are told to report progress monthly to a social worker who calls at the home.

The study, which involved 100 married male alcoholics, was aimed at determining the value of a therapeutic regimen "which might fairly represent the average package of help from a treatment centre anywhere in the western world" compared to a simpler treatment.

Half the men were put in the "complicated" program and half in the do it yourself program.

The two groups were evaluated a year later, and the investigators found the results to be almost identical.

A third of each group had improved to the point of having little or no drinking problem. A third of each group also showed moderate to considerable improvement in marital relations.

Fifty-four percent of those in the do it yourself program and 27% of those receiving conventional treatment traced their improvement to change in "external realities" — finding a more agreeable job or improved housing. Only 4% said social pressures to stop drinking helped their improvement.

Around the World

Food for thought

Christopher Driver, editor of Britain's most popular guide to restaurants, the *Good Food Guide*, has come up with an idea to chew on. He suggested at a conference organized by the anti-smoking lobby group, Action on Smoking and Health, that restaurants should permit smoking only during the last hour they are open. This would mean that diners who choose an atmosphere free of tobacco smoke would have to dine earlier.

A wet martini

Sales of aperitifs and vermouths in Britain went up by 103% between 1970 and 1976, according to a market research survey. During the same period, sales of table wines and liqueurs rose by 40% and 45% respectively.

'Decadent'

The new left-wing revolutionary government in Mozambique, under President Samora Machel, has officially recognized alcoholism as a major social evil to be combatted vigorously. As part of the campaign, the import of alcoholic beverages has virtually ceased. The promotion of traditional African non-alcoholic drinks, usually deriving from generations-old tribal recipes, is an important feature of the anti-alcohol drive. The production of home-brew is being scaled down with production of non-alcoholic fruit drinks being stepped up. The campaign is being spearheaded by the Organization of Mozambican Women.

Kids and alcohol

A survey of *secondary school* students in Auckland, New Zealand, shows 79% are using alcohol, most of them at least once a week, 20% smoke tobacco, and 16% smoke marijuana. The survey of 17 state and private schools was conducted by researchers from the department of psychiatry at the Auckland University School of Medicine. "Alcohol use, unlike tobacco smoking, is the norm for the vast majority of young New Zealanders 15 years and older," they said.

Behind closed doors

The time has come for those who smoke to do so only in the privacy of their own homes, the *New Zealand Medical Journal* has declared. "There is no reason to condone smoking in any public place," it said in an editorial. Smoking is a bad habit and "just as harmful as the more traditional vices," few of which are acceptable in public, the journal said. It called on community leaders, including doctors, to set an example — particularly by not smoking in front of young people. Doctors should ban smoking in the consulting rooms.

Killer drug

British police have been warned of a drug which is booby-trapped so that an officer arresting a drug pusher can be maimed or killed. A person sniffing or licking the powdery substance known as lance, receives a powerful dose of teargas. Lance is similar in chemical composition to CS gas, the successor to teargas, and resembles talcum powder.

Fewer smokers

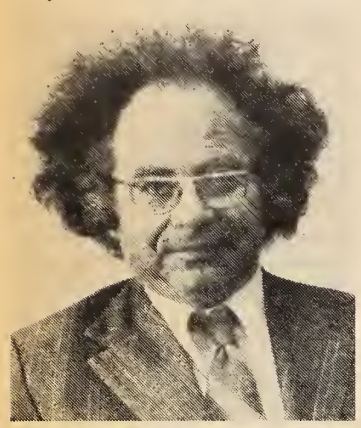
There was a 3% drop in the number of adult smokers in France in the last three months of 1976. French health authorities report the drop in smoking followed a government anti-smoking drive.

Paris addiction centre tries 'a little bit of everything'

By Lynn Payer

PARIS — There are different stages in the course of an addiction, and the space of the treatment must take this into account.

This is the framework upon which treatment of addicts at Paris's Marmottan centre is based. While it sounds very theoretical — and thus very French — the pragmatic correlate is that many different approaches can be used in the treatment of the addict as long as they take into account at what point he is in the history of his addiction.



Samy-Claude Olievenstein

"My personal position," says Samy-Claude Olievenstein, Marmottan's director and undoubtedly France's best known drug expert, "is that nobody has a monopoly on truth, and the best approach is to try a little of everything."

His colleague, Aime-J. Charles Nicolas explained further. Emphasis at Marmottan is not on finding a particular "addict personality," nor is it based on any physiologic definition of addiction.

Rather, he said, it is based on the relation of the addict to his drug, a relation that tends to be passionate. But this passion changes with time, and so do the possibilities of treatment.

• In the beginning is the period of fascination. At this stage, noted Dr Charles-Nicolas, the drug taker is not yet dependent.

"We believe at this stage intervention should be firm and direct. While it can be affectionate, it cannot, even for a moment, be soft. Measures should be taken to separate the person, spatially, from drugs: for example, if the incipient addict still maintains any kind of rapport with his parents, he could be sent to live with them in the country."

• The honeymoon. This period may be long or short, but while it lasts, treatment is next to impossible. The addict gets such pleasure from drugs that it seems the only way for him to live.

"About the only thing to be done at this point is to plant the seeds of a future intervention without moralizing — to let the addict know that if things start going badly, he can come here for help."

• The period of despair. The addict continues to take drugs but no longer gets the "flash" of the honeymoon period. It is now that intervention can start.

Detoxification should not, however, be attempted yet: "It won't work," Dr Charles-Nicolas explained. Psychotherapists at Marmottan believe that detoxification should be preceded by psychotherapy (**The Journal**, September 1976) so the addict is ready to make an investment in his cure.

Dr Charles-Nicolas said that as psychotherapy proceeds, the addict begins to structure his appointments and to arrive more and more regularly. He is now ready to be hospitalized for detoxification.

• Detoxification. It is at this stage that the cure becomes its most authoritarian, and the space must be extremely limited, i.e., the addict signs a contract, voluntarily, to stay in the hospital for at least six days.

Tranquillizers and anti-spasmodics are used, but methadone is not.

During hospitalization, the patient has access to different arts and crafts. Group therapy is videotaped and replayed so addicts can see themselves and, it is hoped, develop a somewhat stronger ego.

Dr Charles-Nicolas explained that during the first three days of hospitalization, there is an extremely close relationship between doctor and patient. After this period, the doctor tries to distance himself somewhat from the patient.

• Postcure. In contrast to detoxification, postcure is not a closed space, and it can be carried out almost anywhere. The ex-addict may be followed-up as an outpatient at Marmottan, particularly if he has a job in Paris; or he may be sent to a mystical community in the country or to a rather traditional medical establishment.

"We have only three conditions that we consider essential when choosing a postcure centre," Dr Charles-Nicolas said.

"One is to watch out for centres run by mentally disturbed persons. Another is that the centre should have a clearly defined project for prohibiting drugs. A third condition is that post-cures are not presented as magic and that they don't give false hopes.

"This third is also one of the most important guiding principles for our own daily work at Marmottan. We try to be particularly careful that the addicts don't see the medications they are given as having any special magic powers."

One of the peculiarities of the Marmottan program is the occasional use of families who "adopt" addicts for short periods of time.

"When this works, it works very well," explained Dr Olievenstein. "The problem is that there aren't that many good families willing to take addicts into their homes."

Drs Olievenstein and Charles-Nicolas admit that it's very difficult to quantify the success of a program at a drop-in centre such as Marmottan. First, large numbers are lost to follow-up and second, Marmottan hasn't really existed long enough to have very long follow-up periods. Nevertheless, success is estimated at about 30% after at least three years.

Success, Dr Charles-Nicolas explained, means not only abstinence from drugs but no excessive drinking, no suicide attempts, and no severe depressive states.

Marmottan—last of a 60s treatment splurge

PARIS — The Marmottan centre, not far from Paris's famous Etoile, was conceived and established in the late 60s as part of a vigorous three-pronged approach to drug addiction taken by the French cabinet then in power. In addition to drop-in centres like Marmottan, the government also had programs for the repression of drug traffic and for information.

Marmottan is about all that remains of the original program. Repression of traffic was essentially discontinued after the "French connection" in Marseilles was dismantled and the Ministry of Health closed its drug information centre because a new cabinet apparently considered drugs were no longer a problem. No new drop-in centres were started, and even the other existing one, in Marseilles, was closed for four years:

Perhaps as a consequence, France is now undergoing an epidemic of drug abuse. There have already been as many drug "affairs" in France in the first four months of 1977 as in all of 1976; and in the same four months, there have already been 35 deaths from overdose as compared to 59 in all of 1976.

Marmottan, which has seen 6,300 addicts since its opening in 1971, is particularly busy.

Besides the quantitative changes, there have been qualitative ones in the addict population. One is the increasing youth of the addicts, now apparently stabilizing. Another is the increased number of females: when the centre opened, there were five boys for every girl; now, the ratio is nearer 2½ to one.

For a while there was a trend to violent behavior but that went out with amphetamines; since most addicts now seen are on heroin, they are not violent.

"The addicts we see now are no longer hippies, they are punks, the most decadent and degenerate addicts we have seen. Their attitude is that 'we have the right to everything'," said Dr Samy-Claude Olievenstein.

Moreover, said the director, they demand their treatment be authoritarian, which creates problems in a place like Marmottan, which attempts to be non-authoritarian as possible.

Cannabis use/criminal behavior link

Scientists say many questions still unanswered

SAO PAULO, BRAZIL — The relationship between cannabis use and criminal behavior is still an open question.

A team from the National Centre for Social and Criminological Research in Cairo has found that within a prison population of 553 users and 458 controls there was no significant association between criminal behavior and cannabis use. If anything, the team found an inverse relationship.

Only 5.7% of cannabis users were found to have had criminal records prior to their current arrest, compared to 13.5% of the non-users.

Nonetheless, M. I. Soueif, chairman of the department of psychology at the University of Cairo, and a member of the research team, says the question of whether or not there is a link between cannabis use and criminal behavior cannot yet be answered.

Speaking to the meeting of the International Symposium on Criminology here, Dr Soueif said that in the 1930s and '40s, the prevailing view emphasized a casual connection between taking cannabis and committing crimes characterized by violence "because of a panic delusional reaction said to be triggered by the drug." In the late '60s and early '70s the prevailing view showed a swing of the pendulum to the other extreme. Cannabis was portrayed as a benign substance which usually enhanced peace-seeking behavior.

"In all fairness, we do not yet have the means to give a valid answer to this complex question," said Dr Soueif.

Commeting on his own study, he said the actual criminal behavior of the prison inmates as revealed by their criminal records should be taken with a great deal of caution. "Our findings mean that our convicted cannabis users were less criminal than our convicted non-users. But this leaves many questions unanswered."

On being questioned, 6% of the incarcerated users emphasized an association between cannabis taking and criminal behavior, and this proportion was found to be almost identical to the proportion of users found to have had a criminal record before their last arrest (5.7%). On the other hand 21.48% of 204 users who were not in prison, when surveyed, underlined a correlation between cannabis taking and crime.

This could mean there is a higher incidence of crime — that goes undetected — among non-prison users, said Dr Soueif. But it could also reflect a "buffer mechanism" to help the non-prison users in calculating risks.

In support of this latter interpretation is the fact the majority of non-prison users took cannabis at moderate frequency (less than once a day) whereas most of the convicted users tended towards heavy use. About two thirds of the convicted users took the drug an average of twice daily.

Further complicating the picture is the fact criminal behavior can be viewed as a pattern or as a specific act, perhaps prompted by specific psychological and/or external stresses.

Of interest here, said Dr Soueif, was the finding that cannabis users became ill-tempered, "hard-headed", impulsive and rather quarrelsome when they suffered drug deprivation.

"Under such conditions, the passage from socially controlled or acceptable behavior to socially uncontrolled or antiscocial behavior seems to become increasingly facilitiated."

Dr Soueif also pointed out that cannabis users were found to have their own ways of not provoking their seniors (employers or parents) to aggressive behavior, but if such methods failed the users reacted in a more aggressive way than non-users.

Criminal behavior, however, is not synonymous with aggression.

"To give an accurate answer to whether or not there is a link between cannabis use and criminal behavior, we should take into account acute as well as chronic reactions to cannabis, and not only to THC, at various times, taken via different routes, in different hosts, within the context of different settings," said Dr Soueif. "Obviously more research is needed."

Insurers cover alcoholism

AUCKLAND, NZ — Alcoholism is an illness and health insurance should pay for it, in the opinion of one of New Zealand's medical insurance funds.

The directors of the Mutual Health Society Ltd have decided alcoholism is caused by events and is not the fault of the sufferer.

"So we will allow it to be one of the sicknesses for which we pay," said a director, M.A.P. Forester.

Mr Forester said most medical insurance companies regard alcoholism as a weakness of character and exclude it from cover.

Mutual Health's directors, mainly physicians and surgeons, treat members as patients and try to take a positive approach.

Recognized alcoholics approaching the society will not receive cover ("Societies don't cover existing illnesses," Mr Forester said), but provision can be made against possible future alcoholism.

Israel preps teachers

JERUSALEM — A comprehensive plan to combat the use of drugs by youngsters, aimed at mobilizing the entire teaching staff in high schools, is now being drawn up by Israel's Minister of Education and Culture.

Aharon Yadlin, the Minister, told the Knesset (Parliament) the plan will be ready for the new school year which starts in September. At first, it will probably be used only in high schools; later it may also be introduced into grammar schools.

The Ministry is also expected to conduct a survey of the frequency of use of drugs among youth. So far, no such survey has been done, and the only statistics available are those issued by the police.

Mr Yadlin said the program would not be based on the "evils" of drugs, for such programs have already failed elsewhere in the world. Rather, it would be aimed at tackling the psychological and sociological problems which brought youngsters to use drugs.

Moreover, the regular school teachers, who come in contact with the pupils and students, will be the moving spirits in implementing the program, not outside "experts". The latter have their place, he said, but only to guide the teachers in their work as well as to lecture to the students. The main burden must be borne by those who come in daily contact with the students and who know them best.

The problem came to a head recently when several student drug users got caught in the Ramat Hasharon area near Tel Aviv. Ramat Hasharon is populated by the upper middle class whose incomes place them much above the national average.

PQ nurses exploring new roles in prevention

By Dorothy Trainor

MONTREAL — Health in its broadest context will be dealt with at a new federally-funded and nurse-staffed health centre in the west island district of Montreal.

The centre named The Workshop (L'Atelier — a votre santé) is the first of its kind in Canada. It has been developed and will be run by nurses from McGill University's School of Nursing.

The project aims "to find out what nurses can do for the community." Health will be viewed in a context that includes nutrition, alcohol use and abuse, cigarette smoking, exercise, parenting, and coping with old age.

The Workshop will present not only a unique health opportunity for residents of Beaconsfield and Pointe Claire but a chance for nurses to explore new roles in preventive medicine.

This affluent area of greater Montreal (80% anglophone) has its share of drug and alcohol abuse problems, particularly among the young, and these subjects among other general health matters will be opened up for discussion. The centre will also deal with the problems of growing up and liaison has been established with school nurses. The Workshop will deal with people of all ages, free of charge, in the two communities.

"But we are not trying to duplicate what is being done by social agencies or the medical profession in the area," states Dr Moyra Allen, director of McGill's School of Nursing.

Already at work are five nurses and three more are expected soon. The nurses plan to improve techniques for preventing the problems they see. Their work begins with an assessment of the individual's health capacity and then nurse and client work together to develop a health regime for which the client will eventually take responsibility.

Seminars, discussions, and particular services will be a part of the centre's work although they will evolve as the needs become apparent.

A team of nurse-researchers, separate from the centre's staff, will also study the health needs of the community and will evaluate the impact of The Workshop on family health in the two communities. In this way, the centre will be a research project in nursing.

One reason for locating the centre in this area is that it is composed of middle-income families, on whom little research has been done in terms of health management.

Incidence may be exaggerated

Alcohol /depression link overstated?

TORONTO — The link between alcoholism and depression may not be as strong as is commonly believed.

Two studies presented to the American Psychiatric Association here suggest the incidence of depression in alcoholics can easily be exaggerated.

The first study, designed to measure depression in male alcholics, revealed that depression is not a common problem in younger, healthier alcoholics, and contradicted the commonly held belief that alcoholics are basically depressed individuals who drink to alleviate their dysphoria.

The second study measured depression in recently detoxified alcoholics. Its results suggest differences in estimates of prevalence of depression among recently detoxified alcoholics depend on diagnostic criteria, and that there is no rationale for treating alcoholism with tricyclic antidepressants.

The first study, conducted by John Hamm, a staff psychiatrist at Bremerton Naval Hospital in Washington, involved 48 male patients who were free from secondary medical illness and who scored greater than six on the Michigan alcoholism screening test. Their mean age was 32.7 years and their mean alcohol consumption in the year prior to admission was 2,286 ounces of absolute alcohol.

Within 48 hours of admission, all patients completed the Zung self rating depression (SDS) and self rating anxiety (SAS) scales. Within 72 hours of admission, they were rated by one of three psychiatrists using the Hamilton rating scale for depression (HDS) and the Hamilton anxiety scale (HAS). All ratings were repeated at three and six weeks.

Dr Hamm found that only four patients had evidence of depression on their initial HDS, but 34.8% had scores greater than 50 (the cut off point for depression) on the initial HDS. By six weeks only one patient had evidence for depression on either the HDS or SDS..

Dr Hamm said the prevalence of depression and anxiety in his study was much lower than that reported by other investigators. "Although 34.8% of our group scored greater than 50 on the SDS, these scores were similar to those reported by Zung in personality disorders, anxiety reaction, and transient situational disturbances . . . Further studies, with close attention to methods of patient selection, will be necessary to clarify what, if any, relationship exists between alcoholism and depression."

In the second study, a team of psychiatrists determined the prevalence of depression among 35 men recently withdrawn from alcohol in the alcoholism treatment program at the Veterans Administration Hospital, Charleston, S.C. Clinical diagnosis, the Zung self rating depression scale, the Hamilton depression scale, and the depression scale of the MMPI were used in this study.

Martin H. Keeler, head of the team, said reports of the prevalence of depression among alcoholics vary from three percent when the criterion is primary affective disorder diagnosed from data derived from a structured interview, to 98% when elevation in either the Zung scale, the Beck depression inventory, or the depression scale of the MMPI is the criterion for diagnosis. Further, he said high estimates of depression have led to the use of anticyclic depressants to treat alcoholism independent of depression.

His study was conducted to clarify the relationship between alcoholism and depression, and to test the validity of such antidepressant therapy.

Results indicated the prevalence of depression was 8.6% when determined by clinical diagnoses and 66% when determined by Zung criteria. The date from the Hamilton scale and the MMPI fell between these two groups. "It is clear that differences in the estimates of the prevalence of depression among recently detoxified alcoholics depend on diagnostic criteria," said Dr Keeler.

"The clinical situation after excessive drinking and/or alcohol withdrawal frequently includes sleep disturbance; many complaints secondary to polyneuropathy, myopathy, or liver damage; gastrointestinal disturbance secondary to gastritis; less sex drive during a drinking spree; poor prospects because of loss of wife, job, and savings.

"These complaints can serve as a basis for diagnosis of neurotic depression, but the clinical pictures associated with excessive alcohol use and present after alcohol withdrawal include neither psychomotor retardation nor agitation nor depressive delusions and resemble neither manic depressive psychosis nor agitated depression. There is no rationale for treating alcoholism with tricyclic antidepressants."

Anti-smokers strike another blow

TORONTO — Beginning next October 1, smoking could become an extremely expensive habit in Toronto.

Violators of a bylaw restricting or banning smoking in public places can face up to a $1,000 fine.

The bylaw, recently approved by Toronto City Council, takes effect October 1 and limits smoking in stores, hospitals, banks, municipal offices, school buses, waiting lines, land reception areas in all offices.

Customers will be prohibited from smoking at service counters in banks, financial institutions, and municipal offices. If a customer continues to smoke after being told not to, he may not be served, and could be asked to leave. If he refuses to leave, police can be called in to press a charge.

Owners and operators of theatres and other public assembly places must have a no smoking section of at least half of their premises. Restaurateurs may provide no smoking areas of up to half of their premises and must post a sign outside their restaurant indicating whether a no smoking area is provided.

Smoking is banned in all reception areas unless a smoking section, taking up no more than half the floor space, is provided. Smoking is also banned in elevators, on escalators, and in stairways of commercial and multiple-dwelling residential buildings, but it will be allowed at lunch counters, in barber shops, hair salons, rest rooms, and staff offices.

It is the responsibility of the proprietor of all types of businesses included in the bylaw, to post no smoking signs and enforce the bylaw with the help, if necessary, of the police.

Proprietors who fail to enforce the bylaw can be fined a maximum of $1,000 — the same as those committing smoking violations.

NY joins pot decrim list

NEW YORK — New York has joined the list of states in the United States that have decriminalized possession of small amounts of marijuana.

Governor Hugh Carey signed the marijuana bill into law on June 29 and it went into effect 30 days later.

The law makes possession of up to 25 grams — enough for 20 or 30 cigarettes — a violation similar to a traffic offence, punishable by a fine up to $100. Second offenders can be fined up to $200 and third offenders can be fined up to $250 or get up to 15 days in jail.

The law also makes possession of amounts larger than 25 grams, or any public use or display of the substance, or the handing of a marijuana cigarette to another person, class B misdemeanors, punishable by up to three months in jail or a $500 fine.

Governor Carey sought passage of the new law after a more liberal proposal stalled in the state assembly.

Cal age limits stays at 21

SACRAMENTO — The California State Assembly has denied 19-year-olds the right to drink.

"Young people have assumed the responsibility not only of voting, but of marriage, contracts, and the like.

"They should not be given limited citizenship," said Assemblyman Louis Papan (Dem-Daly City), vainly urging support for his measure to lower the drinking age from 21 to 19.

Opponents contended lowering the drinking age would increase highway deaths and teenage alcoholism.

Manitoba giving teachers alcoholism lessons

WINNIPEG — The Alcoholism Foundation of Manitoba is teaching Manitoba teachers and high school guidance counsellors skills in recognizing alcohol abuse and in setting up counselling and prevention programs.

The program was conceived and carried out by Pat Koperno, the AFM's prevention and education program development officer, and the first course, consisting of 10 full days of instruction spread over a four-month period, was recently concluded in Winnipeg.

Twenty-two teachers and high-school guidance counsellors took part in the program, which cost the AFM about $8,000 to stage.

"Our philosophy was to give teachers the tools to deal with the alcoholism and other drug abuse problems in their respective city and rural areas," Ms Koperno said. "We were also interested, of course, in equipping them in the ways and means of preventing alcoholism in the first place."

Part of the course was devoted to the proper identification of the drug abuse problems in the areas course participants came from, Ms Koperno said. In most cases this turned out to be alcohol abuse, but some northern area representatives said gasoline sniffing also is a considerable problem in their communities.

One of the course participants has returned to a large rural community where she will disseminate the material covered in the course to all high school guidance personnel in the schools of her division. "The objective of this teacher is to get everyone together and set up a major alcohol abuse prevention program."

Ms Koperno said the alcoholism foundation has traditionally been asked for help only in response to a crisis. "But these teachers know their students, are talking with them on a daily basis and can often sense when a problem is about to come up. That's why we feel a preventive approach is the most likely thing to succeed."

She termed the level of alcohol abuse among Manitoba school children "considerable".

The reason, she said, is mainly that youngsters copy their elders. "These kids see their parents and relatives overcome tensions and nervousness by having a drink."

Moonshiners would rather switch to pot

NASHVILLE — Many Tennessee Moonshiners, facing a losing battle against law enforcement agencies and changing economic conditions, are switching to marijuana as a more lucrative cash crop.

Rising sugar prices, stricter law enforcement, and a diminishing market for moonshine are cited as the main reasons for the change.

Riley Oxley of the federal Bureau of Alcohol, Tobacco, and Firearms, said the price of sugar, a major moonshine ingredient, soared a few years ago. "And that, combined with stricter enforcement of 'white lightning' laws, and a market that's going dry discouraged many longtime whisky runners."

From 1960 to 1968, federal agents in Tennessee seized more than 1,000 stills a year. In 1976, they broke up only six.

"The thing with young people seems to be marijuana and not booze — that's the market now," said Mr Oxley. "The last moonshine we got was going for about $20 a gallon and that was the wholesale price. So by the time the retailer sells it, the price is about the same as bonded whisky."

Another agent said that since most moonshiners are farmers, the next available thing for them to grow is marijuana.

tranquillizers tranquillizers tra

factsheet

During the past 25 years tranquillizing agents have been increasingly prescribed by physicians for a variety of conditions. Unfortunately, the terms 'major' and 'minor' tranquillizer have become widely used. A more acceptable and consistant pharmacological view of these categories of drugs is to differentiate the so-called major tranquillizers by calling them neuroleptics.

Neuroleptics may be taken orally or by injection for variable periods of time. In the treatment of mental illness they are often taken for many years. They have no ability to produce tolerance or dependence. The phenothiazine compounds (Chlorpromazine is an example) have various side effects associated with their use but withdrawal symptoms do not occur when patients stop using them. As it is generally accepted that the neuroleptics do not present an addiction problem, the remainder of this fact sheet considers only the minor tranquillizers.

The group of drugs commonly known as the minor tranquillizers share many properties with the sedative-hypnotics. They have proven anti-anxiety, sleep induction, and general anesthesia ability. They were introduced under the term tranquillizer, rather than sedative, to indicate the calming effect without the stupor or the alarming dependence of the barbiturate type of sedative. Time has shown that they do have the ability to produce dependence and tolerance and that the degree of calmness is dose-related. On the other hand, due to their relatively low incidence of toxicity and their wider margin of safety, they have largely replaced the barbiturates for the treatment of insomnia and anxiety.

Minor tranquillizers currently represent the most commonly prescribed class of drugs in Canada. While usage differs, this class is most often taken to refer to meprobamate and the benzodiazepines. In 1954, meprobamate was introduced and widely marketed under the brand name Miltown. The benzodiazepenes were subsequently developed and since the early '60s have accounted for an estimated half of the total world sales of tranquillizers.

The benzodiazepene developed first was chlordiazepoxide. It was found to be easily synthesized and was mass produced as Librium. The next benzodiazepene developed was diazepam. Marketed as Valium, it has become the most widely prescribed drug in North America. For the last several years diazepam has had the highest sales volume of any prescription item in Canada. Other brand names include Vivol, Viaquil, and E-pam. In addition to their use in cases of insomnia and anxiety, they have proven valuable in several rare conditions of muscle abnormality and status epilepticus (continuous seizures). These drugs and their related compounds are usually seen as tablets or capsules of various sizes, shapes, and colors. They are also available in solution for injection in hospital settings or in dentistry.

EFFECTS

The expectations of the user, as well as the setting, the amount of drug taken, and numerous other factors influence the effects experienced. Minor tranquillizers are widely prescribed to reduce anxiety and most users report reduction does take place. Some drugs relax muscles by suppressing spinal neurons, relieving insomnia and tension states associated with muscle spasm.

Short term effects: In most people a therapeutic dose reduces emotional reactions and mental alertness. Mild anxiety, tension, and agitation are relieved with few significant effects on cognitive or perceptual processes. A person normally experiences relaxation, a feeling of well-being, and perhaps some loss of inhibition. However, responses vary, with some individuals becoming drowsy and others feeling isolated from their surroundings. It is sometimes necessary for the physician to adjust the dosage for individual differences.

As the dose increases so does sedation and a loss of muscular coordination. Some experience a "floating" feeling and most exhibit mental confusion and physical unsteadiness. Occasionally, paradoxical reactions are reported — sleep disturbances, rage reactions, or personality alterations. Other side effects observed include skin rashes, nausea, or dizziness.

Laboratory studies have shown that large quantities of some minor tranquillizers can disrupt performance of certain psychomotor, intellectual, and perceptual functions. It is now being recommended that driving motor vehicles and operating machinery be avoided by those taking these substances. The additional incapacitating effect of adding alcohol or other drugs such as the antihistamines makes such activity particularly hazardous.

Long term effects: People differ in their response to these drugs over long periods of time just as they do in the short term. In some, increased aggression rather than the usual calming effect has been observed. The characteristics of the drugs also vary. Variations are reported in blood levels, metabolism, and the rate at which the drug is stored in the tissues of the body.

It is clear from clinical evidence that dependence on benzodiazepines develops even at prescribed doses. After 10 to 14 weeks, larger doses may be required to maintain the feeling of well-being which the patient is reluctant to forgo. If the tranquillizer is being used to mask symptoms in a situation calling for social adjustment rather than temporary relief, then the long term effect is to postpone seeking more beneficial solutions to problems.

After four to six months of use, abrupt cessation may result in physical withdrawal symptoms. Such discomforts as tremors, agitation, stomach cramps, and sweating subside after two to four weeks. It is suggested that reduction over a similar period of time would return the patient to normal without such symptoms.

Concern is being expressed about the use of minor tranquillizers during pregnancy and lactation (breast feeding). Meprobamate is present in breast milk at higher concentrations than in the mother's blood. While research is proceeding, it is always wiser for a pregnant woman to avoid use of any drugs unless specified by her doctor.

TOXIC EFFECTS

The minor tranquillizers have become second only to the acetylsalicylic compounds (ASA) as a cause of poisoning in Canada. Their margin of safety is so wide that death rarely results from a tranquillizer alone. Most deaths implicate these drugs in interaction with alcohol and other drugs. A combination of factors is probably at work: direct toxicity, drug induced confusional states, depression, the large number of doses available per prescription, and the personality characteristics of the person involved.

Commenting on the increase in tranquillizer reports from poison control centres, Health and Welfare Canada observes that the volume of cases has tended to keep pace with the volume of distribution of these products to the public. International studies have found that the drugs used in suicide attempts correspond to those most widely prescribed and available. About 50% of those attempting suicide are under 30. More are women than men, and depression is the most common diagnosis recorded. A dilemma often noted is that those patients who most commonly require these medications also present the greatest risk for misusing them.

WHO USES TRANQUILLIZERS?

Particular examples of high-risk categories are the alcoholic and the drug abuser. The practice of prescribing tranquillizers to people in these categories or those undergoing withdrawal runs the risk of transferring their dependence to the minor tranquillizer. Cross-addition to alcohol and a bewildering variety of psychoactive and analgestic drugs is increasing. Methadone maintenance programs report that their clients use tranquillizers to enhance the action of methadone. On the other hand, amphetamine users resort to them when they have 'overamped' to counteract the excessive stimulation of the overdose.

However, it is not as a street drug that the vast quantities of minor tranquillizers are consumed. The annual Ontario prescription survey indicated that in 1974 the minor tranquillizers accounted for 45% of all psychotropic prescriptions or about 8% of all prescriptions sampled. Prescription studies around the world tend to agree that the majority of minor tranquillizer prescriptions are written by the general practitioner, more for women than for men, more for people in their middle years. Often prescriptions are refilled without an office visit by the patient. The contribution of various factors to this situation is being studied. These include the effect of advertising in medical journals by drug companies and the pressure anxious patients put on doctors to prescribe pills.

TRANQUILLIZERS AND THE LAW

The regulatory position appropriate for this class of drugs is currently under discussion in the health protection branch of Health and Welfare Canada. At present, they are a prescription drug governed by Schedule F of the Food and Drug Act. The Canadian Medical Association suggested that limiting the number of repeat prescriptions allowed would reduce the potential overuse of this class of drugs.

In Canada it is an offence to drive while intoxicated by any drugs, and the penalties are the same as those for drunken driving.

The Journal

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Clip out this page

New Books

by RON HALL

Alcohol-Related Disabilities

. . . edited by G. Edwards, M. M. Gross, M. Keller, J. Moser, and R. Room

The first part of this report focuses on the alcohol dependence syndrome and the criteria for its diagnosis are discussed. Emphasis is given to the need to identify and treat the underlying syndrome rather than concentrating only on the frequently associated mental, physical, and social disabilities. Many drinkers have a substantially elevated risk of premature death as well as of accidents, and their care may contribute disproportionately to health and social security costs. The report considers how the criteria developed could be used by the community in general and the various persons and agencies dealing with alcohol-related problems. Research questions relevant to the study of alcohol-related disabilities are examined. The second section features papers by individual experts, most of whom were members of the WHO group of investigators who prepared the first part of this report.

(World Health Organization, Canadian Public Health Association, 1335 Carling Avenue, Ottawa, Ontario, K1Z 8N8. 1977. 156p. $7.20.)

Currents in Alcoholism

. . . edited by Frank A. Seixas

Volume 1: Biological, Biochemical, and Clinical Studies
Volume II: Psychiatric, Psychological, Social, and Epidemiological Studies

These volumes represent a collection of the track papers of the seventh annual medical-scientific conference of the National Alcholism Forum held May 6-8, 1976. The first volume contains papers outlining a new test for alcoholism, a new concept of the metabolic changes in fatty liver, the membrane effects of alcohol in the brain and its effect on cyclic AMP, the use of disulfiram, and the question of racial difference in the effect of alcohol. Issues addressed in the second volume include the utilization of lithium and other drugs in the management of alcoholism, parameters of institutional and psychiatric treatment, effects of large and moderate doses of alcohol on the thinking process, and medical education in alcoholism. The social and epidemiological section of this volume deals with different populations of alcoholics, ethnic differences, the identification of heavy drinkers, reasons for drinking, and evaluation of treatment programs.

(Grune and Stratton Inc, 111 Fifth Avenue, New York, NY, 10003. 1977. 10.50/volume.)

Toxicology Annual Volume 2

. . . edited by Charles L. Winek

Included in this volume are articles which deal with veterinary toxicology, laboratory support of drug abuse control programs, beryllium in the environment, XAD-2 resin drug extraction methods, and safety testing of fragrances. Also included are studies of adverse drug reactions, drugs and children, drug abuse proficiency testing, and some historical aspects of marijuana.

(Marcel Dekker Inc, 270 Madison Avenue, New York, NY, 10016. 1977. 290p. $29.50.)

Other Books

Neurology — Mumenthaler, Mark. Year Book Medical Publishers Inc, Chicago, 1977. Translated by Edmund H. Burrows. Principles, clinical neurology, figures, tables, references, index. 452p. $12.95.

Metabolic Aspects Of Alcoholism — Lieber, Charles S. (ed). University Park Press, Baltimore, 1977. Metabolism of ethanol, effects of alcohol on the liver, intestine, heart, skeletal disease, brain, muscle, blood, and bone marrow, endocrine system. Index. 308p. $26.95.

Alcohol — What It Is, What It Does — Seixas, Judith S. Greenwillow Books, New York, 1977. "Primer on the use and abuse of alcohol." 56p. $5.90.

Peer Conducted Research: A Novel Approach to Drug Education — Wenk, Ernst A. National Council on Crime and Delinquency, Davis, 1974. "Paper presented to the First International Congress on Drug Education, held in Switzerland, Oct 14-18, 1973." 31p.

Barbiturates: Their Use, Misuse, and Abuse — Wesson, Donald R., and Smith, David E. Human Sciences Press Inc, New York, 1977. Pharmacology, medical uses, misuse and abuse, complication, dependency, nonmedical aspects, appendexes, references, bibliography, index. 144p.

Annual Review Of Pharmacology and Toxicology, Volume 17, 1977 — Elliot, Henry W. (ed). Annual Reviews Inc, Palo Alto, 1977. 750p.

Toxicology Annual Volume 2 — Winek Charles L. (ed). Marcel Dekker Inc, New York, 1977. Veterinary toxicology, laboratory support of drug abuse control programs, adverse drug reactions, drugs and children, drug abuse proficiency testing, historical aspects of marijuana, appendix, index. 272p.

The Economic Cost of Alcohol Abuse — Berry, Ralph E. Jr, and Boland, James P. The Free Press, New York, 1977. Cost of lost production, health care costs, motor vehicle accidents, cost of fires, cost of crime. 200p. $16.50.

Alcohol Instruction Model: AIM — Dennison, Darwin, Prevet, Thomas, and Affleck, Michael. Department of Health Education, State University of New York, Buffalo, 1977. 121p. $3.

A Family Response To the Drug Problem: Group Facilitator Guidelines — National Institute on Drug Abuse, US Government Printing Office, Washington, 1976. "A family program for the prevention of chemical dependence. 64p.

Nonmedical Use of Psychoactive Substances — Abelson, Herbert I. and Fishburne, Patricia M. Response Analysis Corporation, Princeton, 1976. "1975/76 nationwide study among youth and adults." 142p.

Opiate Dependence — Kuschinsky, K. Gustav Fischer Verlag, Stuttgart, 1977. "Progress in Pharmacology, Vol 1, No. 1." Tolerance and physical dependence, psychological dependence. pharmacotherapeutical aspects, references, index. 39p. $9.50.

Connecticut Action Plan For Alcoholism Prevention And Treatment: 1977 Supplement — Connecticut State Alcohol Council, Hartford, 1977. 150p.

Volunteer Services: A Manual For Alcoholism Program Directors — National Institute on Alcohol Abuse and Alcoholism. US Government Printing Office, Washington, 1976. Appendexes. 68p.

A Comparison Of Alcohol Involvement In Exposed And Injured Drivers, Phases I and II — Farris, R., Malone, T.B., and Lilliefors, H. Essex Corporation, Alexandria, 1976. Tables, figures, appendexes. 104p. $5.50.

Counseling Manual For DWI Counterattack programs — Malfetti, James L., And Winter, Darle J. AAA Foundation for Traffic Safety, Falls Church, 1976. 461p. $5.

Assessment Of The Commissioner's Report of October 1975 — Chalmers, Thomas C. (Chairman), Dorsen, Norman, Astin, Allen V., Cohen, Marsha N., Hamilton, Robert W., Rall, David P., and Weiner, Norman. United States Department of Health, Education, and Welfare, Washington, 1976. Report of the "Review Panel on New Drug Regulation." 650p. $5.

Chronic Hepatitis — Gentilini, Paolo, Popper, Hans, and Teodori, Ugo (eds). S. Karger, New York, 1976. "International Symposium on Problems of Chronic Hepatitis" held in Terme, Italy, April 10-12, 1975. Morphological, histochemical and histogenic aspects, functional aspects, immunological aspects, therapeutic aspects. 205p. $44.10.

In Focus: Alcohol and Alcoholism Media — National Clearinghouse for Alcohol Information. US Government Printing Office, Washington, 1977, "A review of audiovisual materials currently available on alcohol abuse and alcoholics," 73p.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Drinking

Subject Heading: Alcohol pharmacology, impaired driving, overview of alcohol and alcoholism.
Details: 21 minutes, 16 mm, color, sound.
Synopsis: Illustrations show the effects of alcohol on the human body. As the alcohol affects the brain, it also affects behavior. This is shown through the actual behavior of four young drinkers.
General Evaluation: Good to very good (4.6).
Recommended Use: Audiences of 15 years of age and older. May be especially useful for drug users and health professionals working in drug-related fields.

When We Fall

Subject heading: Women and alcohol.
Details: 17 minutes, 3/4" videocassette, color, sound.
Synopsis: Five women are shown who have drinking problems, only one of whom has a stereotypical lifestyle. Of the others, one woman is well-off with a family and friends, but drinks because she is bored; another is a grandmother living alone who consumes alcohol in conjunction with her medication. Yet another is a single parent with two small children who claims to drink for relaxation and escape. The fifth, a professional woman, indulges in heavy drinking as part of her active social and business life. The tape also explores attitudes toward female drinking.
General Evaluation: Very good (4.8).
Recommended Use: Audiences of 15 years of age and older. May be particularly useful to health professionals.

Alcohol: Pink Elephant

Subject heading: Alcohol and alcoholism overview.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: In this animated film, a pink elephant explains alcohol has been around for a long time, and that alcoholism is a big problem in society today. He also explains how alcohol affects a person; why people drink; the stages of alcoholism and what to do about alcohol problems.
General Evaluation: Fair to good (3.5).
Recommended Use: Audiences of 15 years of age and older. The presence of a resource person is recommended.

Moderation At All Times?

Subject Heading: Alcohol, attitudes and values.
Details: Five minutes, 16 mm or videocassette, color, sound.
Synopsis: The film explains that the more alcohol that is consumed in a society, the more alcohol related problems society will have. The animated film advises that lowering the total consumption of alcohol is the key to reducing alcohol related problems.
General Evaluation: Very good, (5.2).
Recommended Use: Audiences of 12 years of age and older.

Sniffing

Subject Heading: Drugs, pharmacology, drug use, etiology and epidemiology.
Details: 15 minutes, videocassette, black and white, sound.
Synopsis: Two young men discuss the pro's and con's of glue sniffing. A physician explains the effects of glue sniffing and the harm it can cause.
General Evaluation: Very poor to poor (1.5).
Recommended Use: Seems to be designed for audiences of 12 years of age and older, AV Assessment group suggests the videotape not be used.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Institute on Addiction Studies — Aug 14-19, 1977, McMaster University, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Drive, Suite 603, Don Mills, Ont, M3C 1Y8.

2nd World Conference on Therapeutic Communities — Aug 21-26, 1977, Montreal, Quebec. Information: Conference headquarters, c/o The Portage Institute, 3418 Drummond Street, Montreal, PQ.

1977 World Congress on Mental Health — Aug 21-26, 1977, Vancouver, British Columbia. Information: Secretariat, World Federation for Mental Health, 2255 Wesbrook Mall, University of British Columbia, Vancouver, BC, V6T 1W5.

21st Annual Meeting of the American Association of Automotive Medicine — Sept 15-17, 1977, Vancouver, British Columbia. Information: Traffic Injury Research Foundation of Canada, 1765 St Laurent Boulevard, Ottawa, Ontario, K1G 3V4.

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

20th Annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9.

United States

International Doctors in Alcoholics Anonymous Annual Meeting — Aug 4-7, 1977, New York City. Information: Secretary, International Doctors in Alcoholics Anonymous, 1950 Volney Road, Youngstown, Ohio, 44511.

Employee Assistance Programs in Institutions of Higher Education — Aug 7-9, 1977, St Louis, Missouri, Information: Employee Assistance Program, 215 Columbia Professional Building, Columbia, Missouri, 65201.

Summer Institute on Drug Dependence — Current Issues, Research, New Directions in Alcohol and Other Drug Problems — Aug 15-19, 1977, Colorado Springs, Colorado. Information: Institute Coordinator, PO Box 1791, Colorado Springs, Col 80901.

Tennessee School on Substance Abuse — Aug 21-26, 1977, Memphis TN. Information: Sam Brackstone, program coordinator, Public Service and Continuing Education, Memphis State University, Memphis, TN, 38152.

6th Annual San Diego Summer Alcohol Studies and Substance Abuse Program — Aug 22-26, 1977, San Diego, California. Information: Karen Lockwood, Univ Ext Q-014, University of California, San Diego, La Jolla, CA, 92093.

6th World Congress of Psychiatry — Aug 28-Sept 3, 1977, Honolulu, Hawaii. Information Rosa Torres, congress coordinator, 6th World Congress of Psychiatry, 1700 18th St NW, Washington, DC, 20009.

International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation Inc, 222 East Redwood Street, Baltimore, MD, 21202.

Alcohol and Drug Problems Association of North America Annual Meeting — Sept 25-30, 1977, Detroit, Michigan. Information: ADPA '77, 755 Big Beaver Road, Suite 2018, Troy Mich, 48099.

National Alcohol and Drug Treatment Outcome Evaluation Conference — Sept 26-27, 1977, Nashville, Tennessee. Information: Linda C. Sobell, director, Alcohol Programs, Dede Wallace Center, PO Box 40487, Nashville, TN, 37204.

1st National Leadership Training Institute on Women and Alcoholism — Oct 3-6, 1977, The American University, Washington, DC. Information: Jan DuPlain, Director, NCA Office on Women, 1925 North Lynn Street, Arlington, Virginia, 22209.

Empirical Approaches to the Treatment of Alcohol and Drug Abuse — Oct 13-15, 1977, Charleston, South Carolina. Information: Catherine Young, department of psychiatry, CSB, Medical University of South Carolina, 80 Barre Street, Charleston, SC, 29401.

6th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

Perspectives in Psychiatry . . . the 1980s and Beyond — Oct 27-28, 1977, New York City. Information: Dean of the Clinical Campus, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York, 11040.

National Community Action Agency — Oct 29-Nov 3, 1977, Philadelphia, Pennsylvania. Information: Together Inc, PO Box 52528, Tulsa, Oklahoma, 74152.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Phoenix, AZ, 85010.

2nd Southeastern Conference on Alcohol and Drug Abuse — Dec 1-3, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

Abroad

International Medical Symposium on Alcohol and Drug Dependence — Aug 28-Sept 1, 1977, Tokyo and Kyoto, Japan. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Behavioral Approaches to Alcoholism — Aug 28-Sept 1, 1977, Bergen, Norway. Information: Peter Nathan, department of psychology, Rutgers University, New Brunswick, New Jersey, 02093.

9th Summer School on Alcoholism — Sept 10-16, 1977, Brighton, England. Information: The Secretary, Summer School on Alcoholism, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, SE5 8Az.

Workshops on Alcoholism in Scandinavia — Oct 4-18, 1977, Denmark, Norway, and Sweden. Information: New York City Affiliate Inc, National Council on Alcoholism, 730 Fifth Avenue, New York, NY, 10019.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Special Symposium on Drug Dependence, 11th International Conference on Pediatrics — Oct 23-29, 1977, New Delhi, India. Information: Dr O. P. Ghai, All-India Institute of Medical Sciences, New Delhi, India.

Asian Seminar on Research and Epidemiology on Drug Dependence — Nov, 1977, Chiang Mai, Thailand. Information: Prof Prasop Ratankorn, director, Drug Dependence Research and Prevention Centre, 268 Rama 6, Phyathai, Bangkok 4, Thailand.

26th Colombo Plan Consultative Committee Meeting — Dec, 1977, Information: The Colombo Plan Bureau, 12, Melbourne Avenue, Colombo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

8th International Institute on the Prevention and Treatment of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

There's no clear advantage

UK doubts growing about heroin maintenance

By John Shaughnessy

WHILE PRESSURE is mounting in the United States to decriminalize heroin and to institute heroin maintenance programs for those addicted to the drug, investigators in Britain — the home of heroin maintenance — are beginning to question the value of such programs.

In the US, as in Britain, the arguments in favor of heroin maintenance generally run that with a legal source of heroin available, addicts will have less need to become involved in the black market and in criminal activities to finance their habits, and will be able to lead more stable lives as a result.

On "therapeutic" grounds, some suggest the availability of a legal source of heroin can serve as a bait for addicts, inducing them to attend heroin clinics and eventually to seek treatment for their addiction.

But a British study on the consequences of maintaining heroin addicts with injectable heroin in comparison with oral methadone, indicates there is no clear advantage to heroin maintenance over oral methadone.

The study was conducted at University College Hospital Drug Dependence Clinic in London and findings reveal that oral methadone prompts a confrontation situation with the addict — he either increases drug use or decreases it substantially.

Heroin maintenance, on the other hand, gives intermediate results. Addicts receiving heroin do not substantially increase their drug taking, but at the same time, few reduce it. In addition, the study found that the availability of legal heroin did not substantially reduce the addicts' involvement in other illegal drug use.

Richard Hartnoll, a research psychologist at the clinic that conducted the study, recently spent some time in North America explaining the British experience with heroin maintenance programs and listening to various proposals for similar programs in the US.

In an interview with **The Journal**, he expressed the opinion that most of the US proposals have little chance of getting off the ground. He sensed a spirit of desperation in some proposals — all other programs have failed. Others, he found self-defeating in that they put too much emphasis on controls.

"If the addicts can't get take-home prescriptions, if they have to go to a clinic every day to get their heroin, the program organizers can hardly expect the addicts to hold down regular jobs and lead 'stable' lives."

More importantly, he said the bulk of data he has seen supports the discouragement of heroin maintenance. At best such programs end up with a group of patients that are chronic long term addicts. Over a period of time, there is very little change in their addiction status, and gradually the group itself increases in size. Overall, said Mr Hartnoll, prescribing heroin can be seen as maintaining the status quo.

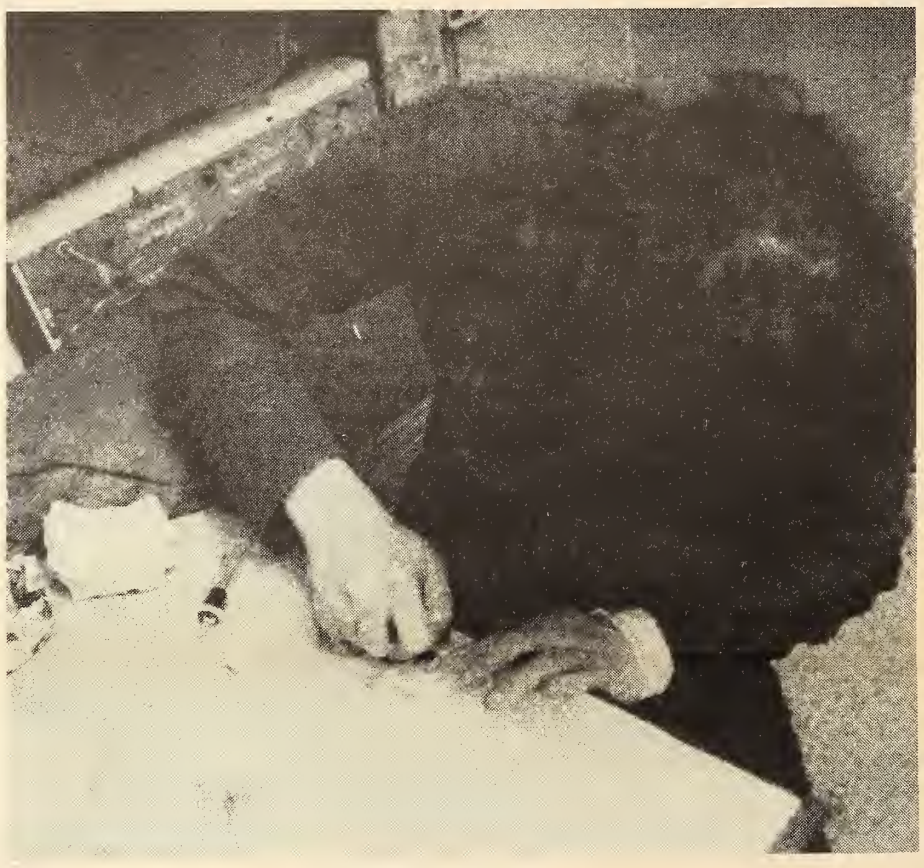
In the London trial, 96 opiate users presenting for treatment at the clinic between February 1972 and February 1974 were selected for a comparison of maintenance with injectable heroin versus oral methadone.

All trial patients were requesting heroin and were accepted by the clinic staff as confirmed heroin addicts. Forty-four received heroin and 52 were offered only oral methadone, but during the trial four patients were crossed over from oral to injectable therapy and were omitted from subsequent followup.

Summarizing the major outcomes of the trial, Mr Hartnoll said that in the 12th month, 32% of the methadone patients and 10% of those receiving heroin were consuming an average of less than 5 mg opiates daily. In the 12th month, 57% of the methadone patients, compared to 90% of the heroin patients, were injecting regularly.

During the final three months of the trial, 30% of the methadone patients abstained from injecting voluntarily for at least 31 days, compared to 5% of those receiving heroin. A further 28% of the methadone patients abstained for between three and 30 days compared to 12% of the heroin patients.

Mr Hartnoll said refusal to prescribe heroin tended to be associated with a higher conviction rate. During the trial, 50% of the heroin patients and 70% of those receiving methadone were convicted of a crime. But there was no difference between the two groups in terms of employment (62% unemployed), health, or consumption of non-opiate drugs.



From heroin . . .

. . . to methadone.

Oral methadone patients tended to polarize towards either high or low categories in terms of involvement with the drug subculture, consumption of non prescribed (illicit) opiates, and criminal activity. Heroin maintenance was associated with intermediate levels of involvement with the drug subculture, illegal drug use, and crime.

"A majority of the heroin maintenance patients in the trial continued to inject heroin regularly," said Mr Hartnoll. "But refusing to prescribe heroin, while offering oral methadone, constituted a more confrontational response by the clinic and resulted in a higher abstinence rate."

Overall, he said, the results of the trial do not provide strong evidence which entirely justifies continuing the current policy of maintaining prescribing with injectable drugs on the one hand, nor on the other do they show that present policies are a clear failure and must be abandoned.

"The differences between the two groups in terms of drug use and criminal activity were not startling, and whichever treatment was given, there were obvious casualties who probably reflect the pre-existing chaos of the patient concerned rather than the treatment offered.

"Within each group there was insufficient evidence to enable a reasonable prognosis to be made as to the consequences of refusing injectable maintenance, but it is clear that providing injectable drugs maintains most patients as addicts and involved in the drug culture."

One problem encountered in the study was that patients met in the clinic's waiting room and often in the community. This sometimes led to complaints if patients believed, correctly or mistakenly, that they were being treated differently from others whom they perceived to have the same drug habits.

Because of this, Mr Hartnoll advocates a uniform policy. "Once an individual patient realizes there is an established policy towards the prescribing of drugs, then there is a more uniform acceptance of that policy even when it conflicts with the patient's immediate wishes. One of the major clinical strains induced by the trial was the maintenance of deliberately arbitrary and conflicting treatments within one setting."

Similar but less immediate considerations apply to differences between clinics within one city and between different cities and countries.

Mr Hartnoll noted that in the early 1960s a number of Canadian heroin addicts went to Britain seeking heroin maintenance, and more recently Europe has seen a congregation of drug takers according to local availability of either drugs or treatment services in certain countries.

"This availability of choice has certain advantages," said Mr Hartnoll. "Zacune's study of Canadian addicts treated in London noted a considerable improvement in their social stability in comparison with earlier experiences in Canada. The provision of a variety of clinical approaches does allow a patient more opportunity to define the sort of help which he wants."

Despite the advantages in variety, however, the policy at University College Hospital is now to attempt to phase out maintenance with injectable drugs, and to offer oral methadone to newly presenting and returning opiate addicts.

As of early 1977, there was no agreed practice common to all the treatment centres in London, but Mr Hartnoll's impression is that the majority have moved toward a policy of not starting any new patients on maintenance with injectable drugs, but continuing to maintain existing patients unchanged, in some cases with somewhat greater emphasis on promoting a voluntary change to oral medication.

One interesting compromise, which at least two clinics are trying, is to offer injectable medication for a limited period of six months, he said.

Turning to the effects of drug treatment clinics on society generally, Mr Hartnoll said a major consideration in Britain has been that the denial of legitimate drugs might result in increasing criminalization of the drug scene. The appearance of illicit imported heroin in England did coincide with the restricted availability of pharmaceutical heroin which followed the establishment of special clinics in 1968. (Prior to that time, any general practitioner could prescribe heroin.)

But Mr Hartnoll noted too that several countries in Europe which did not prescribe heroin before 1968, and therefore could not restrict it subsequently, are likewise reporting a problem of imported heroin from south-east Asia.

"The cost of an illegal drug habit is likely to require an individual to obtain money by illegal activities, and this illegal activity often involves stealing from members of the wider society. The more extensive criminal activities of a minority of our oral methadone group and their persistent use of larger doses of illegal opiates, indicate that this anxiety has some foundation.

"But the total illegal consumption of drugs was the same for the two groups in the trial, and one can only speculate as to the long term consequences of maintaining an increasing number of addicts actively in the drug culture."

Mr Hartnoll also noted that criminal activity of the study groups was by no means always related to a need to obtain drugs.

Another major concern of Mr Hartnoll, and one he feels treatment centres and voluntary organizations must address, is the appearance of young poly drug users whose opiate consumption may be sporadic and of less significance than their consumption of barbiturates, tranquillizers, alcohol, and stimulants.

"Our study did not deal with such patients, but it should be mentioned that they present an increasing problem and one for which hospital based treatment may be quite inappropriate."

Having begun to question the consequences of prescribing with injectable drugs and to adopt a more "confrontational" approach, the clinicians at University College Hospital are still searching for a clear answer. However, they do seem aware of the stakes.

"A decision to prescribe heroin involves clinical, ethical, and political judgments," said Mr Hartnoll.

"In part it depends on views as to the acceptability of the consequences to the patient of long term maintenance, whether medical treatment should be construed to include maintenance prescribing, a personal estimate of the suffering experienced as the consequence of imprisonment, and a doctor's views on his responsibility to society to provide a controlled legal source of injectable opiates even if it conflicts with his responsibility to the individual patient."

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The Journal

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Half price drinks boost use

CAMBRIDGE, MASS — A "happy hour," where drinks were sold at half price, proved to be a powerful factor in the drinking behavior of both moderate and heavy alcohol users.

The finds by a team at the McLean Hospital-Harvard Medical School are similar to those of an earlier study by the Addiction Research Foundation of Ontario.

The Harvard study was of 34 men from the Boston area who were recruited by newspaper advertisements. Twenty men considered themselves casual drinkers, and 14 heavy drinkers, T. Babor said in his report to the meeting here of the Committee on Problems of Drug Dependence.

During their stay, the men worked by manipulating an electronic device, to earn money to buy alcohol, which was sold from 2 pm to 11 pm. They were divided into groups, and each day a different group was allowed a happy hour, while the others paid the normal price.

Dr Babor said: "The casual drinkers in non happy hour conditions consumed about 10 drinks on average over a 20-day period. In the happy hour conditions they consumed twice as much, an average of 20 drinks."

The heavy drinkers consumed an average of 50 drinks over the 20 days in non happy hour conditions, but this rose to an average 117 drinks, or six a day, during the happy hour periods.

Dr Babor said he and his colleagues expected that once the happy hour ended, the heavy drinkers would continue to consume alcohol at the same pace.

The opposite happened. "Their high rate of consumption turned off as soon as the price went up, and they returned to their non happy hour condition. The same was true for the casual drinkers."

Dr Babor said the study "demonstrates quite clearly the cost of beverage alcohol can be a very powerful determinant of drinking behavior, and this is a fruitful area for research and the implications for social policy."

To find a condition in which alcohol consumption doubles provides a powerful impetus for future research.

Most studies, until now, have concentrated on psychological factors, depression, anxiety, craving, and loss of control, which are considered to be personality determinants of drinking. Dr Babor said it could be these factors account for only a small amount of variance in drinking behavior.

This was Toronto's Marijuana Sunday, an event held by the National Organization for the Reform of Marijuana Laws (Canada) to point to the need for legislative changes around marijuana. The pungent aroma of pot wafted across the crowd of some 3,000 gathering in front of Toronto's City Hall. (Photo: Globe & Mail)

NORML tackles law

By John Shaughnessy

CALGARY — NORML (Canada) is planning a major offensive to change Canada's marijuana laws.

According to Ted Siefred, a Vancouver criminal lawyer and the director of NORML (Canada), the group plans to test the constitutionality of the existing marijuana legislation in the courts and to seek permission to prescribe marijuana for a patient suffering from glaucoma.

On the constitutionality issue, Mr Siefred told The Journal his group — National Organization for the Reform of Marijuana Laws in Canada — will argue that the marijuana provisions (in the Narcotics Control Act) are exactly the same as those relating to alcohol. As such, he said, they should be a matter of provincial jurisdiction under property and civil rights, Section 92 of the British North America Act.

Mr Siefred, in Calgary as a lecturer at the summer school on alcohol and drugs sponsored by the Alberta Alcoholism and Drug Abuse Commission, said the constitutionality issue will likely be raised as a defence in a criminal case this fall. The particular defendant will be aware of the organization's strategy and will be willing to fight the issue all the way to the Supreme Court of Canada.

"We well may not win the case on constitutional grounds," said Mr Siefred. "But it will give us a lot of publicity and allow us to bring into court experts from the United States to testify about the true nature and dangers of marijuana."

The plan with the glaucoma

(See — Canada — page 7)

It's a 'fresh' attack on heroin addiction

BC will impose treatment

By Tim Padmore

VANCOUVER — British Columbia health minister, Robert McClelland, has announced a plan for compulsory treatment of heroin addiction which would see people identified as addicts forced to accept up to three years of treatment.

The plan, to be implemented by December 31, 1978, is expected to reach 2,500 addicts in its first year. It will cost $14.2 million in the first year, and $13.2 million in the second, 10 times the amount now spent on heroin addiction by the BC Alcohol and Drug Commission, which prepared the plan.

Mr McClelland announced the proposal at a press conference, saying that BC's drug problem has led to astronomical costs to the justice system and business community and "a new, fresh attack" is needed.

He said legislation, which has full cabinet approval, will provide that any person possessing or administering heroin, or with a history of use, will be subject to examination by a competent evaluation panel.

The panel will recommend whether the person should be committed for treatment in a special treatment centre, sent to the centre as a voluntary patient, referred to a community clinic as an outpatient, or released. The final decision, which the addict can appeal in court, will be made by the director of an area coordinating unit.

Forced treatment in the centre will be for a period of six months, which can be extended with the approval of a board of review. Addicts will normally spend a total of three years under treatment, either in the centre or in the community under supervision.

No evidence of a crime, such as possession of heroin, is needed,

(See — Heroin — page 7)

(See — Fierce — page 7)

DEA cautiously optimistic about US war on heroin

By John Shaughnessy

SEATTLE — Drug enforcement officials in the United States are expressing cautious optimism about their war on heroin.

Peter B. Bensinger, administrator of the US Drug Enforcement Administration, told a meeting here on Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking that recent statistics on heroin addiction and heroin availability are encouraging.

He said for the first time in four years the heroin overdose death rate is down 21%; in the last six months heroin-related injuries have decreased 30%; and most significantly to him, the purity of heroin on the street has gone down from 6.6% a year ago to 5.1%. This purity level is just slightly higher than the lowest level of the early 1970s when the French Connection was broken, and the Turkish government stopped the production and growth of poppies.

In addition, figures from the National Institute of Drug Abuse indicate there is a stabilization in the number of heroin addicts. "I

Canada's pot files

By Bryne Carruthers

OTTAWA — One out of every 135 Canadians is known to use cannabis and has his or her name listed in secret records compiled by the Federal Bureau of Dangerous Drugs.

The Bureau, according to computerized statistics released by the health protection branch of the federal health department last month, has files on 163,279 "known" cannabis users in Canada, 144,110 of whom are male.

The government stresses in its statistics that there are likely more drug users than those whose names are known to the government.

During 1976, almost 30,000 new files were opened in Ottawa, compared to 28,700 files on new known cannabis users in 1975 and 36,494 during 1975 (the peak year).

Of those uncovered during 1976, some 10,971 were between the ages of 20 and 24 years; some 613 were 15 years of age or under; and 73 were over 50 years of age.

More news from Canada's Bureau of Dangerous Drugs on page 2.

In addition, 3,970 persons who had previously been identified as cannabis users were encountered again.

Some 2,500 of the known cannabis users during 1976 were also found to be involved with other drugs, mostly restricted psychedelic drugs like LSD, MDA, and mescaline.

Meanwhile, the number of known hallucinogenic drug users in Canada now totals 21,068, with 1,016 names added during 1976, down from 2,969 added in 1975, and 3,630 added during 1974 (the peak year).

The majority were users of LSD — 584 males and 68 females — during 1976; next ranked were users of MDA, totalling 272 in 1976.

There were 38 new users of psilocybin, none of STP, and one of mescaline.

Regular features

Promise of primary prevention lies in controls

SEATTLE — The hope and the promise for primary prevention of alcohol-related damage do not lie in vague notions of responsible drinking and wise choice by individuals.

Rather, says Paul Whitehead, PhD, chairman of the department of sociology at the University of Western Ontario, London, Ont, they lie in public policy that controls availability of alcohol in line with societal goals and objectives.

Dr Whitehead told a conference here on Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking that despite its widespread use in media and educational campaigns, the notion of "responsible drinking" is at best vague and at worst a myth.

He said programs designed to foster responsible drinking usually focus on two themes. First, responsible drinking is the use of alcoholic beverages by an individual in such a way that it does not lead to damage for that person. Second, persons can have some interpersonal impact on the drinking of others such as the host who pushes drinks or regularly pours doubles or triples. Such practices are said to constitute a lack of responsibility.

Advocates of responsible drinking do not consider the issue of responsibility in a larger social sense, said Dr Whitehead. "They neglect the fact there is a wide disparity between a level of consumption that is not apt to lead to damage for the individual and an average level of consumption for a society which, if achieved, would likely result in high rates of alcohol-related damage. From an epidemiological viewpoint, responsible drinking would have as its prime referent the average level of consumption in a society and not the pattern or level of consumption that is safe or problem-free for individuals."

"Responsible drinking" suggests those who drink and do not experience alcohol-related damage have developed a skill or expertise which has for some reason eluded other drinkers who do experience damage. But Dr Whitehead said it has yet to be demonstrated that so-called normal drinkers or social drinkers have acquired such a skill.

"Attributing a skill to those who drink and do not experience damage is like holding a marksmanship contest where the winners are those who do not hit the target. It makes no logical sense because most people who use drink are exposed to such limited levels of alcohol that they are not at risk."

On a more practical note, Dr Whitehead said educational programs designed to encourage responsible drinking, although ostensibly aimed at changing attitudes, in fact have as their goals changes in drinking behavior. But evidence suggests campaigns about vague notions of responsible drinking may not be effective ways of changing either attitudes or behavior.

Dr Whitehead examined five such programs to assess their impact, and asked respondents whether they had ever seen or heard an advertisement that related to one of the alcohol education-information programs. In Saskatchewan, about 90%, and in Ontario, 85% of respondents said they recalled having heard or seen an ad or heard the program.

However, the Ontario sample was also asked if they had heard of a campaign on "good eating habits" (which did not exist) and 61% replied in the affirmative. "Thus actual recall on this very general question may be closer to 24% than to 85%," said Dr Whitehead.

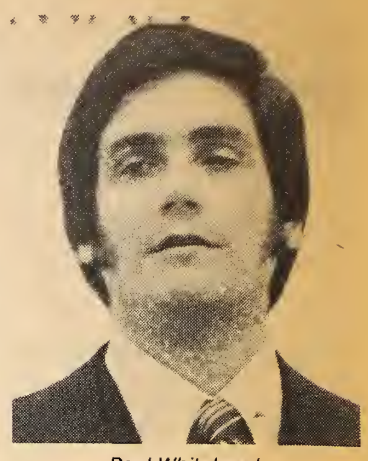
Analysis of the other programs showed similar results, providing only thin evidence that the programs successfully reached large sectors of a mass audience.

Further, in both 1975 and 1976, Dr Whitehead asked respondents in Saskatchewan whether they thought the AWARE program in that province was helpful in changing harmful drinking patterns. In the first year, 67% said "yes" and this dropped to 49% in 1976. When asked whether the program changed their own drinking patterns, only 10% of the respondents in both years said "yes".

"Presumably the difference between the 49% or 67% who feel the program is helping to change drinking patterns, and the 10% whose patterns have changed, is that it is 'other persons' who need it or others who will be affected rather than our respondents," said Dr Whitehead.

Rather than aiming at attitudinal and behavioral changes through educational programs, Dr Whitehead — like de Lint, Schmidt, and Popham — suggests the appropriate target for programs of primary prevention of alcohol-related damage is per capita consumption, with a view to stabilizing or decreasing it.

Dr Whitehead said that, despite



Paul Whitehead

impressions to the contrary, there is a considerable amount of public opinion in favor of policies that would halt the current trend of increasing liberalization of alcohol control measures and add some restrictions to the availability and accessibility of alcoholic beverages.

The conference was sponsored by the University of Washington Alcoholism and Drug Abuse Institute.

ODAP reprieve?

Peter Bourne

WASHINGTON — Congressional objections may lead to a compromise with President Jimmy Carter which will save the Office of Drug Abuse Policy (ODAP) headed by Peter Bourne.

President Carter wants ODAP axed as part of his executive reorganization plan sent to Congress (**The Journal**, August). It will go into effect within 60 congressional working days (October 15) unless vetoed by either house.

During the congressional recess, executive and Congressional staffs have met to try and work out a compromise which could be sent to President Carter, which he, in turn, can submit as an amendment to his reorganization plan.

Congress created ODAP in 1976 to coordinate federal agency programs in drug abuse prevention and control, and many legislations want it to stay in being.

Senator William Hathaway, chairman of the Senate subcommittee on alcoholism and drug abuse, said ODAP's elimination would save only $300,000. It has been created for sound reasons and its demise would be "penny wise and pound foolish," he said.

ODAP will be given until January, whatever happens, to finish policy studies now being carried out on a number of subjects, including law enforcement and drug treatment and rehabilitation.

US drug stage set

WASHINGTON — President Jimmy Carter has told Congress his aim is to discourage all drugs of abuse in America, and also the excessive use of alcohol and tobacco.

Most of the points the President made in his drug policy statement have been predicted earlier by Dr Peter Bourne, White House advisor on drug policy. (**The Journal**, January, June, August).

President Carter said: "We must set realistic objectives, giving our foremost attention domestically to those drugs that pose the greatest threat to health and to our ability to reduce crime.

"Since heroin, barbiturates, and other sedative-hypnotic drugs account for 90% of the deaths from drug abuse, they should receive our principal attention."

The President has proposed a number of concrete steps to be taken on the domestic and international levels.

A study will be made of barbiturates and other sedative-hypnotic drugs to determine conditions under which they can be used safely. Consideration will be given to removing from the market, after review, sedative-hypnotic drugs which are especially subject to abuse.

Barbiturate prescribing habits of doctors will be reviewed and their medical use discouraged. A concerted drive will be made to root out and prosecute doctors who overprescribe drugs such as barbiturates.

On the international front, greater emphasis will be given to international narcotics control programs. Foreign governments will be kept aware of the American desire to curtail production and trafficking of illicit drugs.

The Agency for International Development will be instructed to include crop and income substitution among its programs in countries where illicit drugs are produced.

Solomon lends his wisdom to alcohol debate

By Wayne Howell

One day there approached King Solomon's throne two delegations of experts desirous of having the wise king resolve a most vexing problem: Was alcoholism a disease or was it not a disease?

"What does it matter?" asked the king, who was not in the habit of frittering away his store of wisdom on matters of trivial importance.

"The disease concept is a stumbling block to effective treatment for it allows the alcoholic to avoid responsibility for his own action," said the one delegation.

"If alcoholism is not a disease, then treatment will be set back a millenium for alcoholics will once again be treated as social pariahs," said the other delegation.

Obviously a little wisdom was in order. And so Solomon slipped behind a curtain to consult with his deputy wiseman.

"I think you should pull the same trick you did with those two women and the baby," said the deputy, after consulting his voluminous file of wise decisions. Solomon returned to his throne.

"I decree that from now on, one-half of the alcoholics in this kingdom will be considered sick and the other half shall be considered not sick — we'll split it right down the middle," said Solomon.

This caused a great commotion: neither delegation would budge an inch although there were a few individual representatives who conceded they would accept a 70/30 split provided their side got the 70 and the other side got the 30.

It was obvious to Solomon that a little more wisdom was required. Again he slipped behind the curtain, this time to consult with his full complement of assistant deputy wisemen.

"The wisest thing would be to let the alcoholics themselves decide," said Solomon upon his return to the throne. Immediately there were protests.

"If alcoholics could make decisions of their own free will, they wouldn't be alcoholics," cried the pro-disease faction.

"Alcoholics exercise free will — that is why they are alcoholics," cried the anti-disease faction.

But Solomon had spoken and so drinkers that appeared to be alcoholics, drinkers that professed to be alcoholics, and non-drinkers that claimed they had been alcoholics, were rounded up in the streets of Jerusalem and brought before the throne. Included, for good measure, were some drinkers who claimed not to be alcoholics.

"Speak up," said Solomon, "are you sick or are you not sick?"

Cacophony ensued: some said they were suffering from an illness they were powerless to control; others said they had been sick but cured by an Act of God; some said they just had a bad habit; others said they suffered from an allergy; some said they had unlearned a learned response; others said they were not sick at all — except in the mornings occasionally; some had no opinions; others were full of them; one tourist, a Persian poet, who had been included in the general round-up said he drank because he was an existentialist.

The alcoholics milled about, some gravitating to one delegation, some gravitating to the other, some standing in the middle with bewildered expressions on their faces. Solomon was not amused.

"I decree," decreed Solomon, "that alcoholism is what I decree it is." That seemed to quiet everyone down: now Solomon was going to lay some really heavy wisdom on them.

"Alcoholism," said Solomon, "is a chronic behavioral disorder manifested by the repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or economic function." No sooner had he finished then there was another outburst from the delegations.

"That's too short a definition," cried some.

"That's no good, it requires qualitiative judgements," shouted others.

"It's too long a definition," grumbled some.

"It's descriptive. It's not an etiological definition," said others.

"He said it caused ill health — it has to be a disease," cried the other faction.

Solomon sighed, and went back to his advisors. Ancient precedents were examined, old documents were consulted, and after due consultations the advisors agreed the wisest thing Solomon could do was to allocate government funds so the delegations could pursue the debate in a more ambient milieu.

Solomon returned and made his announcement. All agreed this was an extremely wise decision, one highly indicative of the wisdom of their great king. The only minor point of contention was whether the meeting should take place at a Nubian resort by the Red Sea during the winter months or at a Phonecian mountain retreat during the summer months.

(Wayne Howell is an Ottawa physician and freelance writer.)

Offences top list of drug convictions

Cannabis still Canada's main illicit drug problem

By Bryne Carruthers

OTTAWA — More people were convicted of cannabis offences in 1976 than in 1975, making marijuana and hashish still by far the largest illicit drug problem in Canada, if conviction statistics are any measure.

The 1976 drug statistics released by the federal health department show that there were 34,531 people convicted of crimes under the narcotics control act, compared to 28,733 in 1975.

Of the 34,531, more than 96% — 33,281 convictions to be exact — involved cannabis. And of this number, 31,212 convictions involved simple possession of cannabis, compared to 25,880 in 1975.

Heroin and cocaine convictions during 1976 were down compared to 1975: there were 438 heroin convictions last year, compared to 511 in 1975; there were 265 cocaine convictions in 1976, compared to 289 in 1975.

Phencyclidine convictions also fell to 339 convictions in 1976, compared to 467 in 1975.

Also, 1,168 people were convicted of offences involving hallucinogenic drugs during 1976, compared to 1,903 in 1975. Of these, 789 convictions involved LSD, compared to 1,570 in 1975; and 250 involved MDA in 1976, compared to 318 in 1975.

Not surprisingly perhaps, more than half of the heroin convictions took place in British Columbia, with Alberta second, Ontario third, and Quebec fourth.

For cannabis, Ontario led the nation with about a third of the convictions, followed by Alberta, then British Columbia, then Quebec.

For cocaine, BC was first, and Ontario and Quebec tied for second.

For all narcotic drug convictions, the largest groups of individuals were between 18 and 20 years of age, then the 21 to 24 age group, then the 25 to 29 age group, and then the 15 to 17 age group.

Despite the supposed liberalizing winds sweeping through the courts (far in advance of long-ago promised liberalizing legislation by parliament), people convicted of cannabis crimes (even simple possession) still run a substantial risk of a jail sentence.

While of the more than 30,000 cannabis possession convictions 20,265 persons were given only fines, 2,163 were given probationary sentences, 2,788 were given absolute discharges, and 4,048 were given conditional discharges, 859 were given jail sentences of one month or less, 330 were given sentences of between one and six months, 19 were given sentences of six months to a year, three were given sentences of two to three years, and one was given three to four years in jail.

Two people were put in jail for seven to eight years for simple cannabis possession, three for 10 to 12 years, and three for 20 years or more.

Traffickers in cannabis tended to get six months or less in jail, and two persons got as much as seven to eight years. At the same time, 87 received only fines, 99 were given probation or suspended sentences, and eight got absolute or conditional discharges.

People possessing cannabis for the purpose of trafficking fared about the same, though with a greater risk of stiffer sentences. Two got 10 years or more.

Importers of cannabis generally received seven to eight years in jail. Three got 10 years or more; one was fined; and one got off with a conditional discharge.

People convicted of cultivating cannabis tended to get fines, probation or up to six months in jail. One person got a three to four year jail term.

The number of cannabis convictions during 1976 was the highest ever recorded since statistics were first gathered in 1964; it also reverses a brief downward trend in convictions experienced in 1975.

People convicted of heroin possession either tended to receive light jail terms (six months or less) or fines or probation. The stiffest sentence was for six to seven years.

Traffickers in heroin averaged sentences in excess of three years in jail, with nine persons receiving sentences for more than 10 years in jail. There were no fines or discharges and 10 suspended sentences.

Heroin importers (seven were convicted in 1976) generally received jail sentences in excess of eight years

The number of heroin convictions continues to fall from a high of 1,290 in 1973, compared to 272 in 1964 and 438 in 1976.

Ottawa's secret list growing

By Bryne Carruthers

OTTAWA — Federal drug authorities have added the names of 1,658 Canadian residents to their secret files in Ottawa as known users of narcotic drugs uncovered during 1976.

As might be expected, the largest single group were heroin users — 336 males and 164 females, most of them between the ages of 20 and 30, and most of them in British Columbia (264).

Some 252 new PCP users and 201 new cocaine users were also added to the files at the Federal Bureau of Dangerous Drugs, with most between the ages of 18 and 24.

Surprisingly perhaps, Quebec was among the provinces with the highest number of new known cocaine users, joining the traditional provinces of British Columbia and Ontario.

And while Ontario led with the largest number of new PCP users, Quebec and Nova Scotia were almost tied for second place.

The statistics, compiled by the federal health department each year, reveal that in British Columbia, much of the information on new known narcotic users came from treatment centres. In Ontario, by contrast, almost all the reports came from the police.

For the country as a whole, 1,215 of the new known narcotic users' names came from police reports, out of the total of 1,658.

The 1976 additions bring the total number of officially-known narcotic users in Canada to 15,264 (including 826 under 20 years of age), compared with 10,250 in 1973 and 3,128 in 1966.

Cocaine use reported in US high schools

WASHINGTON — Some eight million Americans have tried cocaine at least once, including nearly 10% of high school seniors surveyed, according to a report issued by the National Institute on Drug Abuse.

The main findings — cocaine is among the most powerfully reinforcing of all abused drugs and can cause psychological addiction — have been reported previously in **The Journal** (March).

These are based on research by Donald Wesson and David Smith of the San Francisco Polydrug Project.

"We have seen cocaine-induced depressions, psychological dependence upon cocaine, acute anxiety reactions to cocaine, and cocaine psychosis," they said.

Dr Smith pointed out most people, including cocaine users, did not appreciate the abuse potential.

Their conclusions are part of the NIDA study which took four years and cost $4 million.

A nationwide survey of high school students found 9% of the class of 1975 and 9.6% of the class of 1976 had tried cocaine.

Robert DuPont, NIDA director, said knowledge of cocaine as a drug of abuse "is still modest."

Dr DuPont warned: "The moderate hazard presently posed by cocaine in the United States may be the result of its high cost and limited availability. Were it more readily available in larger quantity, more serious consequences of use might increase."

David Smith

THC-anorexia nervosa trials begin

By Harvey McConnell

BETHESDA, MD — The first clinical trial using oral doses of tetrahydrocannabinol to try and induce an appetite in young women suffering from anorexia nervosa is underway at the National Institute on Health here.

The trial follows earlier observations that oral THC administered to terminal cancer patients to control nausea from chemotherapy also induces an appetite. (Anorexia nervosa is a nervous condition in which patients take little food, lose their appetites, and become emaciated.)

The trial will be limited to two women at a time, who will spend three months in hospital. Principal investigators are Howard Gross and Michael Ebert, of NIH, and Richard Hawks, PhD, of the National Institute on Drug Abuse.

Dr Hawks says: "What effect marijuana will have is a bit hard to judge, but we do have sufficient evidence to indicate it is quite likely an appetite stimulant.

"Appetite stimulants, as such, have not done much for anorexia nervosa patients as the problem seems to go beyond that. However, marijuana has some interesting effects on neurotransmitter levels and the central nervous system."

Dr Hawks adds that the decision to use THC would probably be too speculative an approach but for two major factors in anorexia nervosa cases: 15% of the sufferers die by the age of 30, and there is no other totally effective treatment.

Most anorexia nervosa patients are in the 18-to-25-year-old age group.

"Behavior modification works to some extent, but it is variable, and it usually does not last for a long period of time," Dr Hawks continues.

"These women are in a sufficiently high risk situation that you are, in a sense, ready to try almost anything that looks like it might do some good. This treatment with THC is not likely to hurt them, and it may well do them some good.

"If we can upset the appetite-psychological mechanism a little bit, maybe they will be more easily convinced to eat. The use of THC will be superimposed on the behavior modification and psychotherapy they will receive at the same time."

During the three month hospital stay, the women will be given graduated doses of THC for two weeks, and a placebo for two weeks.

Because numbers are small, Dr Hawks believes it will be at least from 12 to 24 months before he and Drs Gross and Ebert can draw definite conclusions about marijuana's effectiveness. "That is, unless we see a really dramatic change with the first two patients, and then next two."

Special clearance has been obtained from the Food and Drug Administration because marijuana cannot be used for trials in which the women are of childbearing age.

Almost all anorexia nervosa patients are amenorrhegic. If any patient in the NIH trial starts to menstruate, the marijuana treatment will be discontinued.

Lots of propaganda -- little research

Tobacco industry slams anti-smokers

SAN FRANCISCO — The tobacco industry says it is being victimized by the "tyranny" of such anti-smoking groups as the American Lung Association, the American Cancer Society, and the American Heart Association.

In an address to the American Lung Association's annual meeting here, William Dwyer, an assistant to the president of the American Tobacco Institute, complained about the propaganda against smoking by the Lung Association — the group that sells Christmas Seals and raises nearly $45 million a year for its programs.

And he claimed that only 2% of the money collected by the Lung Association goes toward research grants.

Mr Dwyer said the tobacco industry commissioned a Roper Poll that showed American charity givers typically believe the Lung Association spends 45% of its budget on research.

"It's time to let the giver beware," he said.

He charged that 70% of the money from selling Christmas Seals goes for fund-raising, salaries, and fringe benefits."

Sixteen per cent goes for printing, publications, and propaganda.

And 12% goes for travel and overhead.

Although he admitted the tobacco industry spends almost $300 million a year promoting tobacco, Mr Dwyer said the industry has made no attempt to fight back.

"We have been passive. We have been silent. We have a large reservoir of goodwill," he continued.

"But if there's any consumer in this country that needs protection, it's the consumer of tobacco."

The Lung Association did not dispute the figures cited by Mr Dwyer, but two scientists refuted him when he claimed the relationship between cigarette smoking and lung disease is not yet proven and that only research can offer the final answer.

Dr Claude Lenfant, director of the government's division of lung disease and Dr Stephen Ayres of a federal lung disease task force said seven recent studies involving a million people showed the death rate among smokers exceeds that of non-smokers by as much as 83%.

And they said the single lung disease called emphysema is found in 52% of all those who smoke more than a pack of cigarettes a day, while only 3% of non-smokers develop emphysema.

In the coming year, the Lung Association will focus on three major programs: developing school health curricula to keep the tobacco industry's "prurient advertising" from enticing young people to smoke; testing better ways to help people stop smoking if they want to give up the habit; and increasing "public awareness" of the dangers of smoking.

Harvey McConnell reports from the meeting of the Committee on Problems of Drug Dependence Cambridge, Massachusetts

Addict veterans refute stereotype

QUALITY OF the heroin available — pure in Vietnam and poor in the United States — appears a major factor in the low addiction rate among veterans of the war in Asia.

Results of a three-year study by Lee Robins and colleagues at Washington University, St Louis, "have changed my views of what heroin was like."

Dr Robins told the meeting the study began in 1971 with interviews of a large number of men who had returned in the same month from Vietnam.

At that time, 85% of the men said they had been offered heroin in Vietnam, usually quite soon after they arrived. Some 35% of the men had tried the drug, and 19% said they had become addicted during their year's duty there.

Three years later, in 1974, Dr Robins and colleagues selected 617 men out of the original sample, living in 25 states, and interviewed them about their drug experience since returning home. "For the first time one could look at the natural history of heroin use in a large, unselected group of individuals," she added.

It was found that of the men who had used heroin back in

America, only one in eight had ever received any treatment. This led the team to questions whether the stereotypes about heroin are correct.

From a list of 21 drugs, it was found that the veterans had used 10 more often than heroin and 10 less often.

Among those who used drugs regularly, defined as more than once a week, 30% said they had used marijuana regularly, 16% had used amphetamines, 4% barbiturates, and 3% heroin.

Only 8% of the men had used heroin at all, and only 4% had used it regularly. Dr Robin commented: "Heroin is less likely to be used daily by men who do use heroin than either amphetamines or marijuana."

The study has raised the suspicion that the quality of the heroin available in the United States in 1974 was very poor. In Vietnam pure heroin was available.

"Apparently when heroin is pure it is rapidly addicting, but as used in the United States, there is no difference between it and marijuana and amphetamines.

Dr Robins said the general picture of the heroin addict as a maniacal person who concentrates only on getting the drug "seems to be largely, at least in this population, a figment of our imagination. Part of these ideas are stereotypes from the press, but part are also our own stereotypes.

"Drug researchers have been dividing drug users into heroin addicts and polydrug abusers. I can't tell the difference."

Among the men who had become addicted to heroin in Vietnam, only 12% reported they became readdicted at any time during the three years following their return.

Some 25% of the men who had used heroin in Vietnam said they felt like using it again on their return, but only 4% reported a craving for the drug. Those who reported having a craving apparently had it for a long length of time.

Dr Robins said throughout the study they looked for something "that could predict who could use heroin safely, and who could not. We got nothing but negative findings, so if it wasn't the quality of the heroin I just don't know what it is."

Asked if they thought heroin had done them any harm, most of the veterans said they thought marijuana and amphetamines had done them more harm than heroin. Dr Robins added they probably felt this way because marijuana and amphetamines are more commonly used drugs.

A higher percentage of heroin users think heroin has hurt them than the users of other drugs. However, only 4% of those who had used heroin thought it had done them any harm.

Some 25% of the heroin users considered themselves dependent on the drug. Users of other drugs did not consider themselves dependent, even though they used other drugs every day.

Dr Robins said the study found heroin did not supplant other drugs, it was quite the contrary. "Heroin users were more likely to use every other drug more heavily than non-users of heroin."

In the three-year period, of those who had used heroin, 99% said they had used marijuana, 92% said they had used marijuana several times a week for at least a month, and 34% said they had been addicted psychologically to marijuana.

Only 10% of the heroin users said heroin was their main drug. The other 90% listed marijuana, alcohol, and barbiturates as their main drugs.

When asked what drug they thought had done the most harm in Vietnam, 90% of all the veterans named heroin, whether they had used it or not.

Half of the veterans thought marijuana should be legalized, but only 4% thought there should be any reduction in the penalties for narcotics.

Prenatal aid cuts morbidity in infants of addicted moms

LONG TERM methadone maintenance during pregnancy coupled with adequate prenatal care can significantly improve morbidity and mortality rates among infants born to addicted mothers.

In turn, short term methadone maintenance and inadequate prenatal care does not affect significantly infant outcome rates when compared with heroin users who have little prenatal care, according to L Finnegan, Thomas Jefferson University, Philadelphia.

Dr Finnegan told the meeting the family centre at the university hospital has been designed "to mobilize a woman's lifestyle during pregnancy so she can have the opportunity for regular prenatal care."

In an effort to decrease maternal and infant morbidity and mortality, evaluations are carried out by obstetricians, pediatricians, psychiatrists, psychiatric social workers, and public health and community workers.

Over a six year period, 582 pregnant women were studied: 367 used heroin, or were on methadone maintenance, and 215 women were not drug dependent.

Drug abusers were divided into three groups: heroin users who had little prenatal care; women who were on short-term methadone maintenance during pregnancy and had little prenatal care; and women who were on long-term methadone maintenance during pregnancy, and received adequate prenatal care.

Dr Finnegan said they found heroin users had the highest incidence of obstetrical complications. There was no significant difference in these complications between the two methadone groups and the women who were not drug dependent.

There were striking differences in the rate of low birth weight — infants who weighed less than 2,500 grams.

The rate in the heroin-dependent mothers, and the short term methadone maintenance women, was more than 35%, three times the national average. For women on long term methadone maintenance women, it was closer to normal but higher than for the women who were not drug dependent.

The overall incidence of morbidity in infants born to heroin-dependent women and those on short term methadone maintenance, was significantly higher than among women on long term methadone maintenance.

The incidence of morbidity was significantly higher in the women on long term maintenance than the drug free control group.

Dr Finnegan said they found some 80% of infants born to women in both methadone maintenance groups had mild or moderate withdrawal symptoms following birth, and 10% had severe symptoms.

Among the women who used heroin, 25% of their infants had severe withdrawal symptoms, and 70% mild to moderate symptoms.

The overall incidence of infant morbidity among the women on long term methadone maintenance was reduced significantly over the other two groups of women on drugs. Dr Finnegan added: "It appears that short term methadone maintenance, and inadequate prenatal care, do not significantly improve infant outcome."

When pot is available use of alcohol drops

ALCOHOL INTAKE dropped significantly, and marijuana use increased slightly, when the two substances were offered together during polydrug studies at McLean Hospital-Harvard Medical School.

The findings were in contrast to the assumption before the trial that the simultaneous availability of marijuana and alcohol would result in a combined use of both drugs, N. K. Mello told the meeting.

Sixteen young men, who said they used alcohol and marijuana in moderate amounts, took part. They had no evidence of physical or mental abnormality, they were informed fully of the study, and they were told they could leave at any time.

The volunteers, in separate groups of four, lived on the clinical research ward. During the study, there were five days when only marijuana was available, five days when only alcohol was available, 10 days when both were available, and five days without any drug.

Dr Mello said the heaviest marijuana smokers averaged eight cigarettes a day when this was the only drug available. The heaviest drinkers averaged 15 drinks a day when only alcohol was available.

When marijuana and alcohol were available, the average number of marijuana cigarettes smoked rose to 10 a day, but the average number of drinks fell to five a day.

Even those volunteers who smoked only one or two marijuana cigarettes a day, when that was the only drug available, had a significant drop in their alcohol intake when both drugs were available.

Dr Mello said most volunteers worked at least eight hours a day to earn money. From observations, "heavy marijuana use is not associated with anything we would be comfortable in calling an amotivational syndrome."

The combined heavy use of marijuana along with alcohol did not decrease the number of hours the volunteers were willing to work.

Lithium effect on cocaine doubted

SERIOUS DOUBT about any ability of lithium carbonate to attenuate the effect of cocaine has been expressed by researchers at New York Medical College.

Although the study was small, "the present findings seem to provide substantial evidence that lithium carbonate does not block or attenuate the subjective experience of a cocaine 'high'," A. Washton told the meeting.

Dr Washton said the six subjects who took part in the study were compulsive users who took intravenously from $50 to $300 worth of street cocaine on from three to seven days a week.

Four of the subjects had been opiate dependent and were on methadone maintenance, and two had been detoxified recently and were opiate free.

Cocaine doses tailored for each subject were administered and their subjective pleasure rating measured. Cardiovascular effects were also studied.

Lithium carbonate was then given to each subject and when their serum lithium levels had stabilized, usually within three weeks, cocaine challenges were administered.

Dr Washton said: "Prior to lithium treatment, intravenous injections of cocaine, ranging from 50 mg to 100 mg, produced a modest increase in systolic and diastolic pressure.

"Cocaine administered when the subjects were on lithium had nearly identical effects, with perhaps some suggestion of attenuation of diastolic blood pressure."

All subjects reported a pleasure feeling of substantially less intensity than they had received from a self-administered dose.

Dr Washton added: "Clearly the data indicates the lithium did not block out cardiovascular or subjective effects of cocaine."

Further tests were carried out on one subject who had a strong desire to break his compulsive use of cocaine.

The subject was given a placebo instead of lithium for two weeks, followed by a cocaine challenge. Again he reported the challenge, and a self-administered dose during the previous week did not produce the usual euphoric effect.

Dr Washton pointed out: "Two blood tests confirmed the absence of serum lithium in the subject. However, this finding was inconclusive as we reasoned it could be due to residual biochemical effect of lithium he had been taking for some months, and had recently discontinued."

The subject was told to stop taking placebo lithium. Two days later he was given a cocaine challenge and his rating of the euphoric effect returned to a pre-lithium high.

"We were led to conclude that the earlier finding of attenuated effects of lithium effects on cocaine was placebo."

Dr Washton said they qualified their findings because of the small sample, and the inability to control drug use by the six subjects. Until trials are done on a general population that uses neither opiates nor cocaine, the question of any interaction between lithium and cocaine will remain open.

Heroin users and crimes

AS HEROIN users moved into treatment over a five-year period in San Antonio, so the rate of property crime in the Texas city decreased.

The findings by John Maddux and his colleagues at the University of Texas Health Science Center parallel earlier studies in Washington and Detroit.

Dr Maddux told the meeting all three studies "suggest that approximately one third of the heroin users in the community support their habit primarily by property-related crimes."

NB may soon have drug commission

By John Carroll

FREDERICTON — The Alcoholism and Drug Dependency Commission of New Brunswick, authorized in legislation given Royal assent in May, 1974, may be appointed "before the snow flies," according to provincial health minister, Brenda Robertson.

Mrs Robertson told **The Journal** she is "optimistic that a permanent commission will be appointed by early fall. I had hoped that this could have been in place by late spring this year. However, one has to be sure that it is structured properly."

She said a number of candidates are in mind and as soon as a permanent chairman is appointed, the selection will be narrowed down. "The right chairman is extremely important. Without the right person, the commission could founder. It is also extremely important that the person be sensitive not only to the needs of people, but to the province."

She explained that she believes the commission would function in a smoother manner if the chairman was a person "who understands the structure of the health services delivery system . . . the support capacity available in both large and small communities. This is necessary in order to avoid someone, the commission, expecting too much of the system and then becoming frustrated."

The health minister said it would be necessary for her to introduce an amendment to the Act. The Act provides for the appointment of a chairman, a commission member from each of five health districts, and four members from the public at large. Mrs Robertson said that since enactment of the legislation, a sixth health district has been created in New Brunswick.

The likely avenue open to her is for one of the four members representative of the public at large to be from the new health district. Following amendment of the Act, an 11th member can then be appointed.

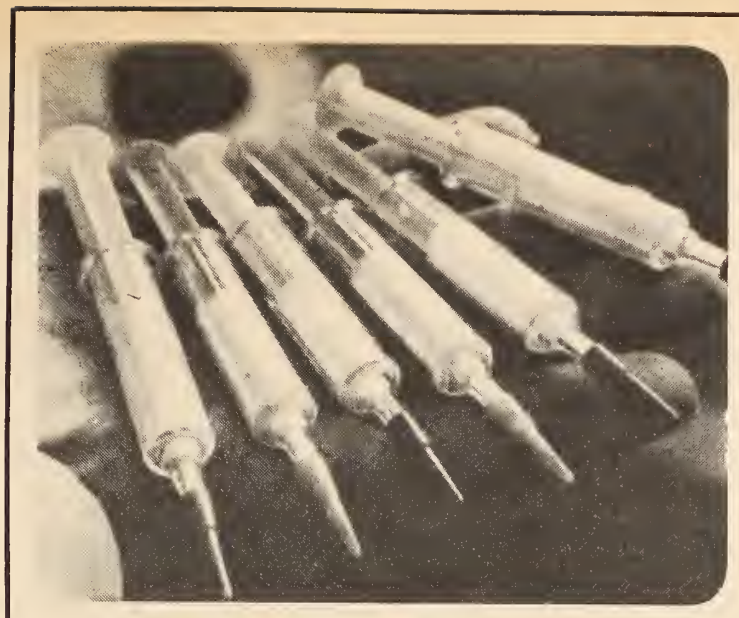
Mrs Robertson discounted financial difficulties besetting Richard Hatfield's government as likely to delay further, establishment of the permanent commission. She said funds had been budgeted for while, in many respects, the permanent commission will only replace existing structures of the alcoholism division of the department of health.

The chairman would be a full-time salaried employee of the department, while the other members would be on a part time basis.

Mrs Robertson said it had not been decided whether the members of the commission would be paid an annual honorarium or receive remuneration on the basis of sitting days.

She said she is "very concerned at not having had this move in earlier because I am most desirous of having the commission established. But I have been reluctant to impose my views because I think that once we find a chairman, he ought to shape the commission's direction. I can assure you we are committed to having this operating before the snow flies."

Brenda Robertson



Kids call candies "dopers"

Hypodermic-shaped packs of candy children call "dopers" are upsetting parents and psychologists in Windsor, Ont. Federal health officials have temporarily halted sales while they test the confection for Red Dye No. 4 which is banned in Canada. The candies are labelled cake decorators but there is concern the holders could condition children to accepting drugs.

Damage to airways, lungs common in heroin addicts

SAN FRANCISCO — Doctors are beginning to recognize that serious damage to the lungs is quite common in heroin addicts.

According to a study at Cook County Hospital in Chicago, heroin addicts who have pulmonary symptoms invariably develop dilated airways or bronchiectasis.

Treatment of the acute complications of heroin addiction with antibiotics and steroids does not necessarily prevent long term morbidity, Arthur S. Banner told delegates to the annual meeting here of the American Lung Association.

But stopping drug use can result in improvement of airway obstruction and lung function.

Heading a team of workers from Cook County Hospital and the medical schools of Northwestern and Loyola universities, Dr Banner performed bronchograms on eight heroin addicts who were referred for symptoms of cough with expectoration or, in one case, an abnormality on x-rays.

Widening of the bronchi was found in all patients.

Under questioning, seven patients related the onset of the pulmonary symptoms to an episode of heroin intoxication accompanied by widespread lung infiltration.

In five patients where previous hospital records were available, a diagnosis of pulmonary edema was made.

The remaining patients were informed they had bilateral pneumonia.

The infiltrates persisted for six days to as long as several weeks in the patients whose hospital course was documented.

All patients had fever at some time during their hospital stay and pathogens were grown from the sputum of three of them.

Dr Banner said it would seem likely the course of all the patients was complicated by infection or aspiration of fluid into the lungs.

Evidence of lung deterioration was shown on pulmonary function tests in seven of the eight patients.

Five showed restriction of the airways, five showed diffuse impairment of breathing, and five had obstructions.

In one patient who continued to use heroin, lung function deteriorated following second and third episodes of pulmonary edema, although there was subsequent improvement in vital capacity and air flow despite continued use.

Another patient stopped heroin use and his diffusing capacity and airway obstruction improved.

Analysis of arterial blood gas showed all patients had a serious lack of blood oxygen and five had chronic hyperventilation.

Dr Banner concluded: "The propensity of heroin addicts to develop extensive bronchiectasis following heroin addiction is unexplained but may be related to bronchial damage induced by aspiration or infection in the presence of increased elastic recoil of the lungs."

Coworkers in the study were Drs Justo Rodriguez, Ettapurayan V. Sunderrajan, Mahesh K. Agarwal, and Whitney W. Addington of the departments of medicine and radiology, Cook County Hospital and Northwestern University and Loyola University medical schools.

Human need for meaning is disregarded

Alcohol and drug abuse reflect society's nihilism

By Dorothy Trainor

MONTREAL — Alcoholism and drug abuse are two of the consequences in a nihilistic society that denies man's search for meaning.

Even in situations of intense grief and suffering, one can find a meaning in life, says Viktor E. Frankl, professor of psychiatry and neurology, University of Vienna, and professor at the American International University, San Diego, California.

The founder of "logotherapy" was in Montreal to address a meeting of the Canadian Association of Guidance Counsellors.

Man's search for meaning has been the *leit motif* of Dr Frankl's writings (some 20 books) and of logotherapy. Logos is the Greek word for meaning and logotherapy focuses on man's groping for a higher meaning. The patient is continually confronted with and reoriented toward renewed meaning in any life situation. Other psychiatric therapies, said Dr Frankl, are too introspective; logotherapy concentrates on the future — assignments and meanings to be fulfilled.

"We cannot always change the situation, but we can change our attitude toward it.

"We are no longer confronted, as much as in Freud's time, with sexual frustration, no longer as in Adler's time with inferiority feelings. Rather we are confronted with feelings of futility and meaninglessness. These feelings are associated with an emptiness, a void, which I have termed 'existential frustration'. As a result, the mass neurotic triad of today consists of depression, aggression, and addiction."

He suggested logotherapy may have more to say in today's technological and nihilistic world than ever. The question of the struggle for survival is over, but the question "Survival for what?" is still open.

There is meaning to be found in life, he said, irrespective of the problem, character traits, sex, age, circumstances, education, or presence or absence of religious faith.

"Man is willing and able to endure stress and, if he has a view of a meaning to be fulfilled, he is prepared to make sacrifices. He is even prepared to give his life. But, if there is no view of a meaning, he is equally prepared to take his life. And this in the midst of an affluent society that is eager to gratify, satisfy, and even create needs.

"But one need is disregarded — the human need for meaning."

Psychology and psychiatry, equally, are disregarding the cry for meaning because most motivational theories ignore the fact man is not essentially concerned with happiness or success of self-actualization but, basically, with finding a meaning to his life, he said.

"To the extent we are serving a cause greater than ourselves or loving a person other than ourselves, to that extent we are human for we are self-actualizing ourselves by giving ourselves."

Dr Frankl scoffed at critics who say he is too idealistic, his theories impractical. His techniques, he said, have been used in psychological and psychiatric studies and also to treat alcoholism.

The American Council of Education published results of statistical research conducted in 316 universities in the United States which queried 189,000 students: 73% said their motivation, their main goal, was to develop a meaningful philosophy of life.

"The will to meaning is man's primary concern."

Yet feelings of meaninglessness are in evidence, he said, not only in affluent western societies but in the Communist countries and even in the Third World.

"Man is no longer told by drives, or instincts, or by tradition, or by values transmitted by tradition, what he must do. He no longer knows even what he wishes to do."

In the United States, he said, the suicide rate as a cause of death among college students is second only to traffic accidents: the number of suicide attempts is fifteen times higher. An Idaho State University study that psychologically screened 16 students who had attempted suicide, found 85% made the attempt because it appeared to them that life had no meaning.

"But of this 85% figure, 93% were physically and psychologically healthy, on good terms with their families, and in good socio-economic condition. They also had had good academic results.

"You cannot explain such a statistic unless you hear something — the unheard cry for meaning. A 'will to meaning' as I expressed it 30 years ago, has been frustrated — a will to meaning that man has an innate and deeply rooted desire to find and to fulfil a meaning in life situations.

"The Declaration of Independence contains a paragraph which refers to the 'pursuit of happiness'. The pursuit of happiness is a contradiction in terms. It is the pursuit, I dare say, that obviates it. Happiness cannot be pursued. It must come to you all your life as a by-product. But if you aim at happiness or pleasure, you cannot gain it."

His techniques, he said, are used "to help the patient to resume self-transcendence of his personality, that is to say to forget himself by giving himself."

But exactly how does the counsellor give meaning to the troubled individual's life?

"Well, in the first place, don't take it away. Don't indoctrinate nihilism," Dr Frankl emphasized.

It is a matter of using the person's potential. As soon as the individual becomes aware he can do something about reality, he sees many possibilities and his life takes on a new perspective.

"There is a universal human potential to turn tragedy into personal triumph, a predicament into an achievement. To find meaning in suffering is the highest achievement — a fulfilment in spite of failure."

This, he concluded, is the antithesis of what we see in the world today — despair in spite of success.

Treatment focus destructive

Karin Pargas reports from Futuraction, the 12th annual conference of the Canadian Addictions Foundation, Winnipeg, Manitoba.

THE CHEMICAL dependence field will lose its prominence and programs will stagnate unless there is a dramatic change in current approaches to addictive behavior.

The restrictive emphasis on the treatment of alcoholism has led already to loss of priority in some jurisdictions, Carl Stroh, a psychologist with the Newfoundland department of health, said.

Coupled with the loss of priority, Dr Stroh said, there will "almost inevitably be an ever-increasing degree of program stagnation. Faced with the prospect of endless 'band-aid' operations and the inability (because of a lack of bureaucratic or political support) to begin addressing the real problem which we now choose to ignore, the best people will leave the addictions area.

"Behind them will be left those who will be content to occupy our money and their time with endless variations on the same themes . . . two-day detox, three-day detox, 15-day detox . . . "

Dr Stroh said the broad, comprehensive approach to the addiction phenomenon emerged briefly in the late 1960s when a wide variety of drugs was being used.

"(Now) we rationalize our concentration on alcohol by telling ourselves it is the biggest problem. We then convince ourselves it is wise and good to deal almost exclusively with treatment because we know so little about prevention. If we continue to pour all our human financial resources into treatment services, we never will know anything about prevention."

He said alcohol is not so much a problem as a symptom of a problem.

"The pressures and forces which result in some people becoming addicted to chemicals are the same ones that result in the other more innocuous-appearing addictions like television viewing, participatory and spectator sports, eating, sex, or even hunting and fishing."

Dr Stroh said workers in the field should reaffirm their continuing concern for other chemical abuses and, in particular, devote more time to studying the abuse of prescription and non-prescription drugs, cigarettes, coffee, and tea.

It is also necessary, he added, to commit thought to a preventive approach and "suppress our natural tendency to be concerned exclusively with substances."

The public must be educated, concerned, and vocal about addiction. If not, politicians cannot be blamed for refusing to take aggressive action.

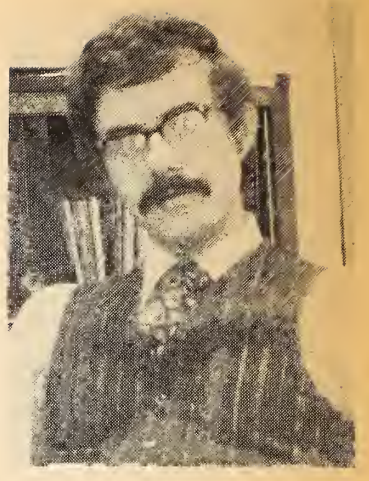
For the moment, there are "three simple actions which a genuinely concerned and responsible government would take to help reverse the present trend towards addiction," Dr Stroh said.

- The government should begin actively to discourage tobacco growing in Canada. "In a world where starvation is the future for many millions of children, it is criminally irresponsible to allow some of the world's prime agricultural land to be devoted to the growing of a non-food substance."
- Smoking should be banned in public places. "The aim is not only to protect non-smokers from inconsiderate smokers, but also to create a social environment for children in which smoking plays little or no part. In this way, it might be possible to encourage future generations not to succumb to tobacco smoking."
- All promotion of alcoholic beverages should be banned immediately, including promotional activities such as sponsorship of sporting events. "Politicians will have to deal with advertising firms which will lose money; the media, which will lose money because of lost advertising; Canadian grape growers who might feel threatened by anything which threatened their market, and; amateur sports organizations. Concerned citizens will have to be particularly vocal, aggressive, and persistent to effect any real change in this area."

Concluding, Dr Stroh said: "Our society's continued devotion to its addictions, coupled with neglect of responsibilities for helping solve the worldwide problems of famine, energy shortage, over-population, ignorance, and political unrest, constitutes one of the biggest cop-outs of all time.

"Unless we can act to reduce the level of addiction in our society and begin to meet our responsibilities to the world community, our society will be forcibly withdrawn from its addictions by outside agents of the third world.

"We must give up our addictions and foster alternatives which are meaningful to our society and to other societies as well."



Carl Stroh

Drinking public ripe for norms change

CANADIANS HAVE learned important facts about their personal drinking habits since a national program on responsible drinking began more than one year ago.

And the public is now ready for a change in the norms associated with drinking, Ron Draper, director-general of the Non-Medical Use of Drugs Directorate told the conference.

A recent federal survey, implemented to measure the effectiveness of Health and Welfare Canada's $679,000 Dialogue on Drinking campaign, revealed that most people still feel pressured to drink, but want to be able to refuse a drink without being considered in the minority.

Dialogue on Drinking provided encouragement and support for many people to refuse that first drink, turn down a second, or cut down their overall consumption, Mr Draper said.

Dialogue had as its target audience, the 12 million Canadians who are estimated to drink responsibly. The program was not aimed at the 700,000 who drink hazardous amounts of alcohol, he said.

Mr Draper said there were two reasons for addressing the six print advertisements and six radio commercials at moderate drinkers: "First, to let them know that they are a part of the majority, and to help them retain their responsible approaches to drinking; and second, to help them share their convictions with immediate social contacts — families, friends, and fellow workers."

Mr Draper said Ottawa will launch the second phase of the Dialogue on Drinking campaign in early 1978, at a budget of $1 million.

"Our messages for Dialogue II are now envisaged as becoming more specific about personal responsibility and behavior, addressed more directly to better target groups, and transmitted via a sharpened and broadened use of media."

Labrador natives being destroyed by alcohol

LIQUOR DISTRIBUTORS in northern Labrador are no better than profiteering drug pushers because alcohol is destroying the lives of the native people.

And it is ludicrous that the planes that bring in supplies of alcohol to a settlement in northern Labrador, are the same planes that load up with convicted alcoholics to transport them to the penitentiary in St John's, Newfoundland, says Alan Pallett.

Mr Pallett, who works for the International Grenfell Association, which operates northern hospitals for the Newfoundland government, told delegates the alcohol abuse problem in northern Labrador is reaching "epidemic" proportions.

"Surely it must be a disgrace that, on top of having no running water in their ghettos, they are being increasingly damaged physically, mentally, and socially as the distributors search for profits," he said.

"It is a shame the native people are getting to such a low ebb because of alcohol abuse at a time when they need their strengths to adapt to the benefits of acculturation."

Mr Pallett said the native people will pay $20 for a bottle of bootleg liquor and are willing to travel 60 miles in sub-zero weather to obtain beer. Home brew is also popular, he said, and one store sold 850 50-pound bags, or $30,000 worth of sugar, in a one-year period. In the search for mind-altering substances, the Indians of North West River have misused the alcohol content of vanilla extract for many years.

Another example of the increased drinking that has hit northern Labrador, Mr Pallett said, can be seen "in the massive thirst of the Hopedale Eskimos. Last year, they had enough beer to keep the 160 legal-aged drinking population in an alcohol stupor for 24 hours a day."

Mr Pallett said the historical pattern of native alcohol use in northern Labrador is similar to that elsewhere in Canada. The northern Labradorians did not react unusually to their first taste of alcohol: they learned their drinking habits from white people; there was, and still is, an exploitation of the native people through the "convivial" use of alcohol by white people in their associations with the native population; and the native people incorporated alcohol as one of their main recreational outlets which "thus serves a community need."

That alcohol provides fraternity is witnessed, Mr Pallet said, by the example of the Montagnais Indians who gave up living in tents "and succumbed to the civilizing influence of the white man. As their tents disappeared, so did their tribal unit. It has been suggested that alcohol is being used to replace their former unity. Whereas before, caribou was shared as part of a ritual, now alcohol is shared but without the same significance. The former sharing meant pleasure, but the latter type of sharing usually means trouble."

There can be little doubt, Mr Pallet said, that the native people have been damaged psychologically by their contact with whites. This oppression can be seen in their passive, resistant behavior, disinterest in their futures, and suspiciousness of and lack of cooperation with white people.

"Native alcohol abuse must be prevented by comprehensive programs which make inroads into every casual factor," he said.

"There is little point in trying to curtail the native peoples' demands for alcohol if the availability problem is not equally curtailed." The prevention of the problem can be brought about by the use of social planning by those responsible for the health, welfare, and social development of the native people, he said.

"We believe there is a chance that natives of northern Labrador will emulate other native people in Canada, and set up programs to avoid their destruction. In the meantime, great patience and understanding will be needed in trying to help and prevent the trouble that alcohol abuse is causing these shy, resourceful, and hardy people."

Priority to ad bans

THE CANADIAN Addictions Foundation has resolved to work for a ban on all tobacco advertising and promotion, and a gradual end to alcohol advertising.

Delegates said here such dangerous drugs as alcohol and tobacco should not be promoted.

The resolution on alcohol, which is to be forwarded to appropriate provincial and federal authorities, calls for the immediate enforcement of existing broadcast regulations that would put an end to lifestyle advertising. The resolution calls also for a reduction in the size, style, and frequency of alcohol advertising in progressive stages.

CAF chief mum on cannabis

THE NEWLY-ELECTED president of the Canadian Addictions Foundation refuses to say whether cannabis should be legalized because all the costs have yet to be measured.

Marvin Burke, executive director of the Nova Scotia Commission on Drug Dependency, said the introduction of another substance might mean a doubling of the current social and economic costs of alcohol use.

However, he asked: "What would the costs be if we don't do something (about cannabis) — the judicial costs, costs of policing, and what it's doing to youths' attitudes to the law?"

In Nova Scotia, said Mr Burke, 88% of the convictions under the Narcotics Control Act and the Food and Drug Act are for simple possession of cannabis. If charges for trafficking and possession are added, the conviction rate will go up to 92%.

Mr Burke said the emphasis of the CAF in the coming year will be to press for greater government action in regard to chemical dependency, particularly on prevention efforts.

"The CAF will attempt to speak loudly so we can support provincial and federal governments in the creation of programs for people in trouble with chemicals," he said.

"Change for the better is possible," he said, "but it won't come without growth and pain."

Dr Lorne Phillips, director of prevention, education, and staff development, Alcoholism Foundation of Manitoba, has been elected vice-president of the CAF, and William Murphy, area manager, federal department of fisheries and environment, Prince Edward Island, has been elected secretary-treasurer.

Marvin Burke

Canada will decriminalize pot in next two years

(from page 1)

proposal is to find a person with glaucoma, and apply under the provisions of the Narcotics Control Act for a licence to prescribe marijuana. Mr Siefred said the organization will go further than to attempt to get a licence to use marijuana for experimental purposes.

"What we'll say is that it's been proven in the United States that marijuana is an effective if not the only treatment for glaucoma; here's the data from the US; this person wants to use it. We'll assist the person in getting a licence from the federal government to use the drug and not for experimental purposes but for on-line usage. Even if we are not successful, our effort will presumably bring to the public's attention the fact that marijuana is not a killer weed."

Asked why he thought the federal government had delayed as it had in reforming the marijuana laws, Mr Siefred said Ottawa's main consideration in doing anything is political expediency.

"They admit there's nothing wrong with dope, and they don't care if people are going to jail for dope (offences). The majority of the people still have a prejudice against dope, so there's no way the government is going to say there's nothing wrong with it, the laws must be changed.

"They have managed to defuse the issue. They were completely successful with LeDain in dumping the matter for three years. When the LeDain report came out in 1971, there was a little furor and then it died down."

According to Mr Siefred, the main marijuana myth today is being promoted by the government and the police. "They say marijuana is no longer a police priority and that just isn't the case. In 1974, the most recent year for which the federal government has statistics, there were 49,000 arrests for marijuana, 3,000 for hard drugs.

Marijuana plant

"The majority of the people believe people are no longer being prosecuted for simple possession of marijuana. It's true that most of those caught for simple possession are not going to jail, but between 1973 and 1975, 3,000 people did — at a cost to the taxpayer of $17,000 a year.

"What we're saying is that the government is wasting our money. They say it's being spent on the heavy drugs and substantial traffickers and that's simply not true. It's being spent on people who are smoking reefers, on people who are selling lids in bars."

Despite the government's seeming apathy, Mr Seifred predicts marijuana will be decriminalized in Canada within two years. "I'm not an optimistic person, but decriminalization is going to happen. The worst that's going to happen is that we'll follow the United States.

"My conservative prediction is that marijuana will be decriminalized federally in the United States within a year. Within two years, 40%-45% of the individual states will have decriminalized it, and at that point the Canadian government will follow suit. Looking at it from the most cynical viewpoint, the Canadian government will have to decriminalize because American tourists will be coming up here and smoking marijuana and getting hassled."

Meanwhile, NORML (Canada) is putting out as much educational material as it can from its Vancouver office. Members of the organization give speeches, distribute literature, and participate in talk shows on radio and television. Mr Siefred said they are also conducting a survey of federal members of parliament. "A questionnaire has been sent out asking them how they feel about marijuana, and we're getting some feedback. We've got to know who our friends are.

"Our position on marijuana has not changed. We support the removal of all criminal and civil penalties for the private possession of marijuana for personal use, and the right of possession should include other acts incidental to such possession, including cultivation and transportation for personal use, and the casual non-profit transfers of small amounts of marijuana."

Mr Siefred added however that NORML (Canada) fully supports a discouragement policy towards the recreational use of all drugs, including alcohol, tobacco, and marijuana.

Fierce opposition, neutrality greet BC treatment proposal

(from page 1)

only evidence of addiction, such as needle marks, withdrawal symptoms, or chemical traces in the body.

Suspected addicts could be referred to the evaluation panel by a court, which might agree to suspend sentence or make treatment a condition of probation; by a prison official on the release of an inmate; by the police; by a doctor or hospital; or by the user or his family.

Reaction to the proposals ranged from neutrality to fierce opposition.

BC Civil Liberties Association spokesman, Reg Robson, said the program won't succeed in eliminating the province's heroin problem and described it as a "punitive action" against addicts.

Association president Jim Dybikowski said: "You are taking a prison and putting the sign 'hospital' on it."

Former health minister, Dennis Cocke, now in the New Democratic Party opposition, predicted the program will be a costly mistake.

Judge Darrell Jones, of the District Court, said: "It's a departure from the procedure that the court is familiar with but suggesting it's different doesn't suggest it's not as good. Extreme measures are sometimes necessary."

But, he noted, similar programs of compulsory treatment of alcoholics do not seem to have been successful.

Dr William Tysoe, president of the BC Medical Association, said "my personal reaction is one of hope" but added he had reservations about whether the program might simply lead to pushers going out and recruiting still more addicts.

Dr Scott Wallace, leader of the provincial Conservative party, said he agrees with the program in principle, but said strong safeguards will be necessary to prevent abuse.

Federal government ministers were unsympathetic.

Marc Lalonde, minister of health, said: "There are very serious legal problems regarding human rights. I don't know whether British Columbia can do this under existing legislation."

Justice minister Ron Basford, who, with Lalonde, had been negotiating with BC on approaches to the heroin problem, said he was upset that Mr McClelland had not informed him of the initiative.

"It seems a very strange way to ask for money," he said when asked if the federal government is likely to contribute.

However, Mr McClelland said at the press conference that he did inform the federal ministries, and said he expects the federal government will chip in "the major costs of the program."

He as much as admitted he was forcing the federal government's hand, saying: "It was time some responsible government took some action."

(A federal-provincial panel appointed last March to find ways of solving the heroin problem, and given 60 days to do it, has yet to reach a conclusion.)

Mr McClelland acknowledged the plan could make problems for other provinces by driving addicts out of BC. One reason for the delay of a year in implementing the plan is to give other provinces a chance to respond, he said.

Commission chairman, Bert Hoskin, opened the press conference with statistics emphasizing the seriousness of the heroin problem.

BC had about 6,600 addicts in 1975, he said, an increase of 167% since 1970.

He said the drug trade is the province's fifth largest "industry," with gross sales estimated at $255 million and much of the money obtained through crime.

Mr McClelland said a variety of treatment approaches will be tried, including cold-turkey and slow withdrawal, methadone substitution, and behavioral and therapeutic community methods. The goal in all cases will be abstinence. Treatment will be supplemented by job-training and job-finding services.

He said he hopes most of the people entering the system will come as volunteers. To encourage them, there will be a three-month grace period at the start of the plan during which any one will be able to enter the system as a volunteer.

Mr McClelland said volunteer referrals will be less likely to be sent to the closely supervised treatment centre, a 150-bed facility to be built somewhere in the Lower Mainland.

Treatment for outpatients will be at a series of community clinics in Vancouver, Victoria, Nanaimo, Kamloops, Prince George, Chilliwack, and other centres.

The health minister said he expects many addicts "will simply leave the system" either by giving up their addiction on their own or by moving away.

That is what happened in Japan after that country introduced its compulsory heroin addiction treatment system, the model for the BC plan.

Last fall, after a visit to Japan, McClelland expressed reservations whether that system would work here. The Japanese culture is different, he said, with people having more respect for their government, and there being more willingness among addicts to volunteer for treatment and more readiness amongst friends and family to turn them in.

Asked about his earlier remarks, he said: "I believe there have been significant changes in the attitude of the people of BC in recent months."

He credited part of the change to efforts to publicize the costs of drug-related crime and said the educational campaign will continue in order to "gain public support in far larger measure."

Heroin costs DEA 55% of total effort

(from page 1)

believe this will continue, and the number of addicts will decrease as heroin becomes less and less available, less pure at its retail distribution level, and more dangerous to distribute," said Mr Bensinger.

Heroin is the DEA's major single drug priority, and the administration recently increased the money, time, and manpower it devotes to this enforcement problem from 38% to 55% of its total efforts. But Mr Bensinger stressed that to have a truly significant effect on the problem, ther must be close cooperation on an international basis.

"I believe that's happening," he said. "The Mexican government's program of spraying poppy fields is meeting with success — heroin is becoming less available and less pure. At the same time, in order to head off alternate sources of supply, a Southeast Asia heroin working group has been established to identify the major trafficking organizations in Southeast Asia.

"We've been meeting with officials from Canada, Thailand, Burma, Japan, Korea, Hong Kong, Indonesia, and Western Europe, and there has been a great improvement in law enforcement intelligence interchange and effort.

"We're trying to prevent what happened after the French Connection was broken up and Turkey stopped producing poppies. In the last 16 months we've been working very hard, and we believe successfully, to see that Southeast Asia does not step in and take Mexico's place as a source of opium and heroin for international distribution."

On the domestic scene, Mr Bensinger said there is still no meaningful deterrent to drug trafficking. "The enormous money and power involved in the syndicate organizations in drug distribution are sufficient to have bail considered as an expense and a year in prison as a meaningless temporary deterrent."

In 1975, of 3,995 cases resulting in convictions in federal court for heroin and cocaine, one of three individuals received a sentence of probation. Of those sent to prison, only one of three received a sentence of three years or more. "In 1976, looking at 919 cases, we found over 50% of all offenders receiving sentences of less than 10½ months. We found that 42% of the people arrested by the DEA were recidivists, individuals previously arrested and convicted of narcotic offences.

Peter Bensinger

"I am not asking for sentences that are mean, but I am requesting that we consider sentences that are meaningful."

Asked if this meant mandatory minimum sentences for drug traffickers, he said sentencing guidelines would be a more prudent and acceptable solution. "If you're talking about someone who is distributing in excess of ounce quantities of heroin, we're looking for sentences that would result in imprisonment for in excess of three to five years.

"At the present time, sentences are characterized by an inconsistency which I don't think is acceptable. We've had an individual in Chicago who distributed pound quantities of heroin, receive a sentence of probation. We've seen individuals in New York who not only distributed large ounce quantities of heroin to our agents, but tried to bribe them and shoot them, receive five-year sentences."

Another problem in the drug enforcement system is the lack of a systemic approach. "It's no good to add a sanction without the resources to carry it through," said Mr Bensinger.

In his view, the so-called tough Rockefeller drug laws did not fail, they were never implemented. "When those laws were put into effect in New York State, 31 special courts were directed to be made available for drug offences, a special prosecutor was appointed, and he was to get help from a lot of US attorneys. But the chief judge of the district ruled that these courts could not handle narcotics offences alone, but would also be available for general felonies.

"So, of 500 individuals arrested by the police commissioner, 10% were dismissed, another 20% were dismissed because of the probability of acquittal, and for the balance, at their preliminary hearing, sentences were given out as time already served and minimum fines were imposed. No one was indicted, no one went to a grand jury.

"It's no good to have agents if you don't have prosecutors to prosecute the cases; it's no good to have tough drug laws if you don't have indictments."

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Letters to the Editor

Fact sheet friend

I want you to know how much I appreciate the fact sheet on tranquillizers in the August issue of **The Journal**. I will circulate copies of this outstanding article among my patients and throughout the community.

I will study the publications of the future in anticipation that your fact sheets will provide similar coverage to such drugs as birth control pills, aspirin, allergy drugs, and hormones.

Possibly there are times when you really wonder about the long range or even short range effectiveness of your publications. Information from **The Journal** is passed on continuously to the young people coming to me as patients, as well as parents, in health lectures I give every week.

Keep up the good work.

James R. Douglas, DC
Wellington St N
Woodstock, Ont

Aussie greetings

Wishing **The Journal** and all its staff a very happy fifth anniversary. **The Journal**, in my opinion, is one of the most informative, educational, and instructive publications on drug matters I have read.

I hope it continues to prosper. This view is also shared by members of my Drug Squad in New South Wales, Australia. **The Journal** is always up to date with topical material and drug matters, which of course is most desirable.

Please continue the good work and, once again, congratulations.

Det/Sgt Ken Astill
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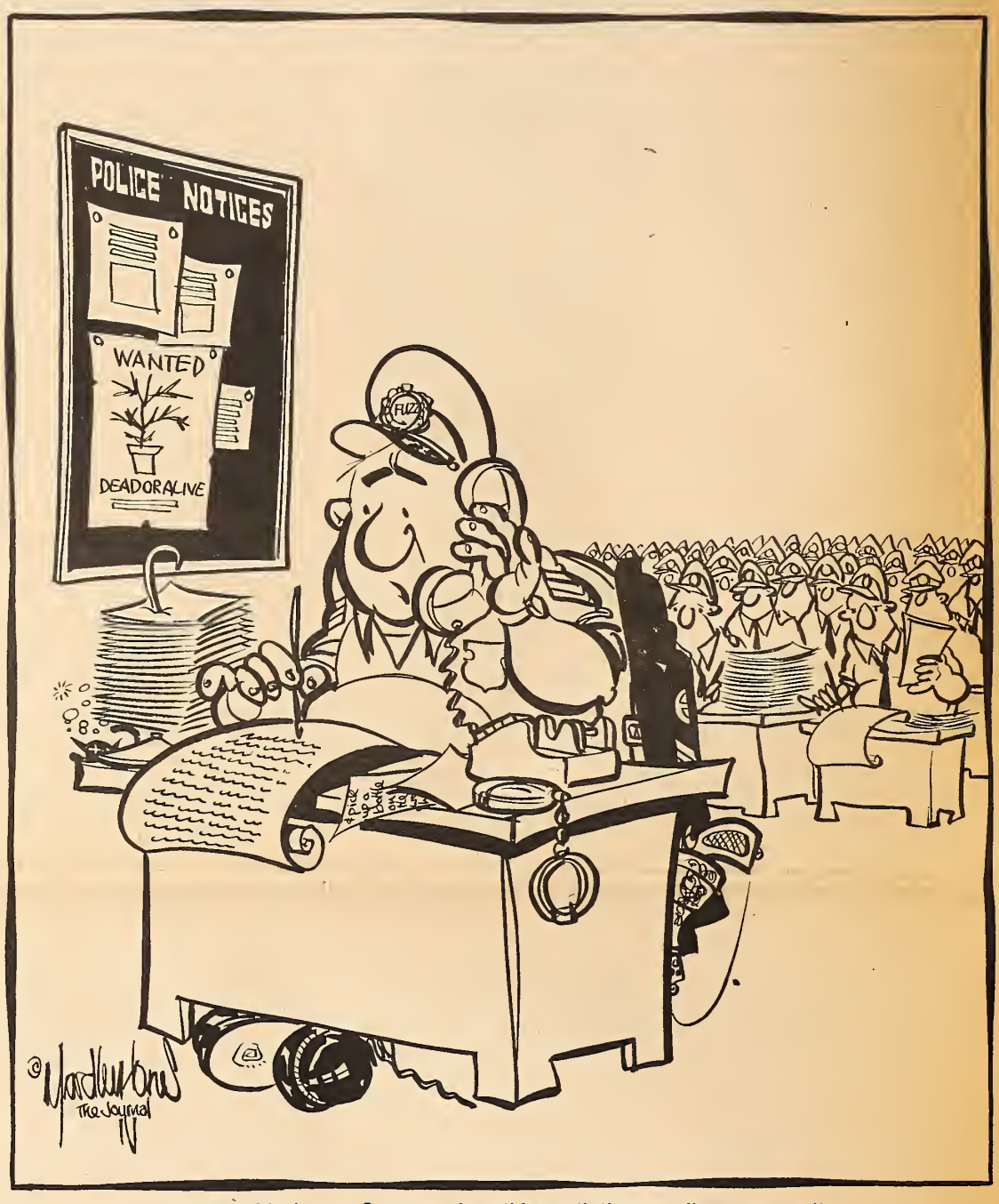
The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1. We reserve the right to edit all correspondence.



"Rape, Madam — Sorry, we're all busy listing marijuana users"

Inside Science

Counselling tool is simple,

By Jerry J. Danic*

In addiction counselling, I have developed a treatment process which is (1) short term (usually one hour per week for four to five weeks), (2) fairly structured in terms of information gathering and goal setting, (3) sometimes directing, i.e. I tell people exactly what I expect from them, and (4) emphasizes quick results.

To succeed, I need to know quickly and accurately the main problems in the person's life; what specific behaviors or lack of behavior causes problems, e.g. inability to communicate; what childhood experiences may be causing problems; if the person's self-esteem or self-image is low or high; and something about present experiences.

I have devised the Quick Personal Inventory Scale to give me much of this information. It is a 30-item scale, takes about 10 minutes for most people to complete, and most people do it without difficulty.

It has several advantages in addition to providing information quickly.

- It immediately identifies problem areas in a systematic way.
- It gives a quick and easy measure of self-esteem, i.e. if a person scores mostly 1 and 2 items, a low self-esteem is indicated. (I have no measures of reliability for this as I believe self-image is very difficult to quantify.)
- It gives us something definite to start talking about.
- In counselling couples, areas of disagreement are quickly revealed and may be explored with the couple.
- It sometimes indicates where people have unrealistic views of themselves, i.e. they score high but have many problems, or the spouse has scored low in the same area.
- It can show people themselves, not just the counsellor, their problem areas.
- It can be used to illustrate progress over a period of time. (Scorings change as treatment progresses.)
- It helps people to open up when they have difficulty admitting the truth or are simply not talkative people.
- It can help people to understand what effect their past has had on them. Usually, we uncover negative programming on the part of parents and this can be discussed.

I find that once people understand their behavior, and some of the reasons for it, they have more power to control present behavior. Sometimes, the scale does not work well or isn't needed. When a person opens up quickly and easily, the counsellor may find most of the items already covered. Some people misunderstand the terms and make mistakes.

However, in the majority of cases, the scale helps and I have yet to see how anyone could be hurt by completing it. I believe it could also be useful in, for example, marital counselling.

However, since it is a tool, it requires that the user develop methods of using it. What might work for me may not work for another therapist. It is also important to note that the scale is only of value when it fits into the total counselling process. Without the other exercises the client does, it would not be enough. With them, it is very useful.

*** Jerry J. Danic is centre director for Lambton County Programs of the Addiction Research Foundation of Ontario, Sarnia office.**

THE DANIC QUICK PERSONAL INVENTORY SCALE

Please circle the number that best fits the way you feel in relation to the word or words given. Use your past experience or your present feelings as they pertain to the word or phrases.
For example, for the word "marriage". If your marriage is a very good and/or positive experience, circle the number 5.
If you feel your marriage is average, circle 3, and if your marriage feeling or experience was/is bad, circle 1.

1. Marriage
2. Your children
3. Finances or Money
4. Work
5. School — early years
6. School — now
7. Church/God
8. Communicating
9. Cooking
10. Discipline (self or other)
11. Love
12. Faith
13. Trust
14. Sex
15. Body
16. Health
17. Intelligence
18. Emotions
19. Friends
20. Career
21. Alcohol/Drugs
22. Housework
23. Your Childhood
24. Your Parents (when you were young)
25. Your Parents (now)
26. Brothers & sisters (when you were young)
27. Brothers & sisters (Now)
28. The future
29. How do you feel about yourself?
30. How do you feel about the opposite sex?

Backgrounder

Singapore takes drastic action

By Tony Garnier*

SINGAPORE — The Chinese Year of the Dragon, 1976, has already been recorded by Singaporians as the most unfavorable ever for the island's 8,000-plus heroin addicts.

The Year of the Serpent, 1977, seems likely to be far worse.

A sharp rise in the use of heroin in 1975, especially by youngsters including the sons and daughters of prosperous Chinese families, effectively ended a debate on what should be done to solve the problem. In a remarkable and unnerving expression of consensus, Singapore's social workers, doctors, educators, lawyers, and police, and as far as it's been possible to assess, parents, are united in the belief that "where social persuasions and precept fail, the full impact of the legal sanctions must apply without compunction."

The invariable explanation is that Singapore is a City-State of 2.2 million people crammed on to an island of 229 square miles, where a person's value is measured by what he can contribute to the economy.

If 8,000 people are not working, they are a drain on the prosperity of the rest of the community. Consequently, the freedom of the individual "to do his own thing" comes second to a responsibility to contribute as an economic unit.

Drug addiction has grown so serious that many believe the very fibre of Singapore's lifestyle and values has become threatened. In the words of the minister of home affairs and education, Chua Sian Chin, "an all-out war" to break the backbone of the island's drug problem has been launched.

Measures introduced last year included:

- Making the death penalty mandatory for trafficking in heroin and morphine in excess of 15 and 30 grams respectively. In the first year, seven death sentences were passed and 21 others charged with trafficking await trial.
- Amending legislation to permit the director of the Central Narcotics Bureau to by-pass the Courts and send, direct to a drug rehabilitation centre, any person who fails a urine test (as North Americans may fail a blood test on the way to facing a drinking-driving charge).
- Establishing a new drug rehabilitation centre based on "cold turkey" techniques, where an addict must stay a minimum of six months.
- Making aftercare compulsory for two years after discharge from the drug centre.
- Enlisting and training part-time counsellors from the ranks of compulsory military trainees (who have to serve two years) to help at the drug rehabilitation centre and with aftercare.
- Launching a massive campaign for volunteer social workers and funds through the top strata of Singapore society, the first-ever effort of this type since World War II.

In addition, consideration is being given to amending legislation to give professional social workers powers to conduct urine tests on those on aftercare following discharge from the rehabilitation centre. The aim is to provide means of detecting any return to heroin use.

In 1973, when drug rehabilitation began in Singapore, methods of "social persuasion" were attempted. A centre was opened on nearby St John's Island with the objective of keeping addicts from drugs and out of reach of suppliers.

As Mr Chua described it, addicts went through a daily routine "not unlike that of a holiday camp". Those heavily addicted were given methadone in decreasing dosage to help them through the periods of pain and craving that occurred as they supposedly dried out.

However, in two years of operation, 80% of those who left the island were soon back, addicted. Also, as has happened elsewhere, a tendency developed for addicts short of funds to volunteer as patients so as to make use of the drugs offered under the replacement therapy.

St John's has since been closed and turned into a holiday resort. Since April 1, 1976, addicts have been sent to a former army camp, Telok Paku, where instead of replacement therapy they now get "cold turkey" for the first 14 days.

The process occurs in two specially constructed "padded" cell blocks. Addicts are stripped naked and given no medication, having to withstand sometimes severe pain, twitching, shaking, sweating, vomiting, abdominal cramps, and, in some cases, severe hallucinations.

Says a senior Singapore social worker: "The aim is simply to allow the drug addict to fight his way through withdrawal and in the process experience intense suffering. It is felt that the agony and fear of the withdrawal experiences will always remain in the addict's mind and, perhaps, help him resist the temptations of further drug abuse."

The day "cold turkey" ends the addict begins a totally regimented and compulsory six months of work therapy and counselling. Addicts work an eight-hour day at full pay on electronic component assembly, bag making, and furniture polishing. The reasoning here is that previously addicts who were found jobs after release from St John's could not hold them because their capacity for sustained effort had been seriously impaired both by the addiction and the leisurely pace at which they were permitted to cure themselves.

Telok Paku opened with 50 admissions and nine qualified aftercare officers from the social service department. In six months, the number of addicts rose to about 900.

To deal with the increased numbers, groups of national service people are being trained as aftercare officers. By March, 240 servicemen, chosen through psychological test methods, and mainly from the professions and business fields, had been trained.

Each serviceman is assigned a caseload of three addicts. He will meet the addict both individually and in groups, find him a job prior to release, and for the two year aftercare period, check employment, family relationships, and associates, watching whether the former addict is establishing a new lifestyle or reverting to former habits and "friends". The officers are expected to respond to all calls from their three charges, and complete appropriate reports sifted from the professional officers.

Is it working? Clearly, Singapore has put considerable work into its "war" against drug abuse. A similarly intensive campaign is being waged in the area of restricting availability of heroin through a joint effort by customs and police. All authorities agree, however, supplies are still easily obtainable, a situation likely to continue for some time.

After eight months of the new rehabilitation program, authorities claim that just two of nearly 100 who have completed six months at Telok Paku have returned to heroin. This compares favorably with the previous 80% relapse rate. But there could be others.

"We won't really know till the new urine test law is passed," said one social worker.

There is a reluctance to talk about the "cold turkey" approach or about concern at the legality of locking up young people without court sanction. It is something that has to be seen in the context of Singapore's identity, said one social worker. Another authority pointed out it was working in Japan and "so far", he said, no one had died.

Others agree there are problems with the new program, especially related to over-crowding and classification, keeping first from habitual offenders. However, additional buildings are planned.

To many Westerners, Singapore's drug rehabilitation scheme may seem excessively tough.

However, in the Singapore context its determination to come to grips with the drug problem reflects a measure of deep concern about the future of the island's young people. Sixty percent of the population is aged less than 21.

By involving national servicemen from many of Singapore's top business and professional families, the government has greatly increased the community's awareness of the extent and tragedy of drug addiction.

The success of the scheme will depend upon the maintenance of interdepartmental communication and training, said one official. For the scheme's inception, police received social work training, social workers received police training. And both groups received training on health aspects. The belief is that if one sector is weak, then this failure will be recycled through the whole system.

**This is the second in a series of articles by Tony Garnier, political correspondent for The Evening Post newspaper in Wellington, New Zealand. He was awarded the 1976 New Zealand Mobil Overseas Travel Award to travel around the world for four months to study political, social, and personal aspects of the drug problem.*

loesn't hurt

GOOD		AVERAGE		BAD
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Comment

BC's taking a big risk against unsure odds

By Tim Padmore

VANCOUVER — It is a serious step to deprive a person of his liberty. Such a step can only be justified by the need to protect society from potential harm, or to punish an individual for harm already done.

British Columbia health minister Bob McClelland argues that his plan to force heroin addicts to accept up to three years of compulsory treatment, six months or more of it behind locked doors, is justified by the extent of heroin-related crime.

There are several problems with the argument.

The health minister and the provincial Alcohol and Drug Commission, which prepared the treatment plan, cite police estimates that 60% of crime is drug related, and ring up a corresponding $110 million share of yearly court and police expenses against heroin addiction. Gross sales of heroin are put at $255 million (two $35 fixes a day for 10,000 addicts, 365 days a year). People, it is said in the commission's report, are afraid to walk the streets at night.

The basis of those estimates is weak.

The 60% figure comes from a finding that 43% of adults arrested for robbery in 1975 were known heroin users, as were 53% of those charged with holdup offences, plus an adjustment to account for unknown users. But that isn't to say all those crimes were committed to get money for heroin.

Indeed, studies indicate heroin addiction is usually incidental to criminality.

Furthermore, it is believed a relatively small fraction of the cost of drugs comes from crime.

The United States National Institute on Drug Abuse estimates that 30% to 50% comes from selling drugs to other addicts, that addicts cut down when money is low and switch to other drugs, and that many addicts hold jobs.

It is doubtful, therefore, that anything like $255 million is ripped off from ordinary citizens.

The estimate of 10,000 addicts is out of line. The number is a police estimate. Elsewhere, the commission cites figures in the range 6,000 to 8,000.

Even the more conservative figures are likely exaggerated. They come from the federal Bureau of Dangerous Drugs, which keeps addicts on its list for 10 years unless it hears of their death, deportation, or cure.

Workers in the field estimate the number is no more than 2,000 or 3,000.

But all this is quibbling. Even if the estimates were 10 times too high, the costs of heroin addiction would be large.

Truly disturbing is the other part of the argument: Because some addicts commit crime, all addicts are to forfeit their liberty. It is analagous to the justification for incarcerating Japanese Canadians in the last war, except that in the present case, there is no national emergency to which to appeal.

The other argument for forcible treatment is that it is for the addicts' own good.

Not that we would presume to coerce people to visit dentists or psychiatrists, even though tooth decay and neurosis can make their lives miserable.

In the case of heroin addiction, there is not even the promise of an effective cure.

Commission chairman Bert Hoskin boasts that 400 of the 516 addicts currently in ADC treatment programs have been off heroin for six months, but concedes that 90% of those are dependent on methadone, although abstinence is the stated goal.

One of the most spectacular treatment failures ever was the attempt to rehabilitate drug offenders at the Matsqui federal institution in the Fraser Valley. The program, which was started in 1966, was quietly abandoned when authorities discovered the recidivism rate was 86% after five years.

It was, needless to say, a compulsory program, although the coercion was confined to convicted criminal offenders.

There is preliminary evidence that coercive approaches can work, however. An example is the contract approach worked out by Henry Boudin at the University of Florida. He finds that people referred to him by the courts as a part of their sentencing are more successful even than volunteers.

But the evidence is just that — preliminary. Mr McClelland is taking a big risk in wagering civil rights and tens of millions of dollars against uncertain odds to win a pot whose size is equally uncertain.

A pilot program would have been a cheaper way of resolving the uncertainties.

The decisive stroke was more to Mr McClelland's taste, however.

Perhaps the gamble will pay off. That would be little enough comfort to those who cherish civil liberties.

Perhaps it will not. That is the scary thing. How easy will it be to dismantle a legal and bureaucratic apparatus become needlessly oppressive, but oppressive only to a politically powerless minority?

Response mixed to UK cigarette ad restrictions

By Alan Massam

LONDON — The long-awaited, tightening of British cigarette advertising rules, announced on July 27, will restrict claims that smoking can make people healthy, wealthy, sporty, or, if female, more sexually attractive.

But the announcement of the terms of the new "voluntary code of conduct" by health secretary David Ennals brought immediate protests from the medical anti-smoking lobby Action on Smoking and Health (ASH).

Mr Ennals said the changes had been agreed with the tobacco companies and the Advertising Standards Authority and would apply to cigarettes containing tobacco substitute as well as all-tobacco brands.

Advertisers would have to avoid suggesting:

- That smoking was healthy or free from risk;
- That a particular brand proves manliness, courage, or daring or that it enhances feminine charm;
- That smoking leads to success in sport;
- That the habit is associated with the rich and the successful.

Mr Ennals said the new code would operate for a three-year period.

Mike Daube, director of ASH, said later the changes were an important step forward, but still fell far short of the controls necessary to reduce significantly the smoking habit.

He added: "This strengthened code is a welcome response to pressure, and marks yet another nail in the coffin of tobacco promotion.

"We are particularly glad to note that cigarette advertisements are now forbidden from featuring associations with sport and from appealing to women through linking smoking with 'feminine charm' or from associating smoking with wealth and successful living.

"Health claims have been banned, and advertisements for substitutes have also been brought under control. This is long overdue and again an important development in view of recent events" (the big promotion campaign for tobacco substitute cigarettes currently in full sway here.)

Mr Daube, who is now by far the most effective "irritant" to the tobacco companies, went on to say that the new code was, however, "little more than window dressing in the absence of a cigarette advertising ban."

He stressed such a ban had been called for by the World Health Organization, the Royal College of Physicians (which sponsors ASH), and the British Medical Association, and had already been implemented in 12 countries.

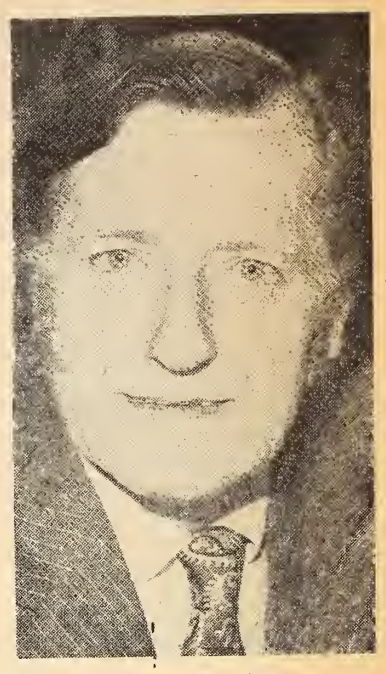
"Tinkering with voluntary codes is evidence of government concern, but also of inability to take effective action," he said.

"This year the cigarette manufacturers will spend well over £80 million on advertising and promotion. No voluntary code will be able to reduce effectively the impact of such expenditure. Yet again, political expedience has prevented the government from taking action it knows to be necessary."

The ASH director said the new code must ultimately be judged on its impact.

"We fear, however, that as in the past the new code contains too many loopholes," Mr Daube went on, "and may be weakly interpreted by the ASA. If this happens, the three-year period of grace announced by Mr Ennals could be a serious mistake.

"The new code still depends on voluntary agreements and covers only certain forms of direct cigarette advertising: it does not apply, for example, to advertisements for sponsored events. And while sportsmen or spectators may not be shown, there is no restriction on the use of sporting equipment such as cricket bats or tennis racquets. Indeed, it is ironic that while cigarette advertisements are now forbidden to imply that smoking is associated with success in sport, cigarette sponsorship of sport continues freely."



David Ennals

Tobacco substitute advertising misleading

By Alan Massam

LONDON — The launch in Britain of 11 new brands of cigarette containing a proportion of tobacco substitute material (on July 1) has aroused anguish and concern among the anti-smoking lobbyists.

In fact Action on Smoking and Health, the campaigning group set up by the Royal College of Physicians, said the marketing of the new brands had shown "lack of concern for public health."

And the National Society of Non-smokers said the British government was being "irresponsible" in authorizing the use of the tobacco substitutes.

In a letter to the British secretary of state for health and social security, David Ennals, ASH director Mike Daube said: "Much of the publicity for these products has emphasized their novelty, giving the misleading impression that novelty in itself brings a reduction in health hazards.

"Advertising and public relations activities in preparation of the launch of part substitute cigarettes have been of an unprecedented intensity, without control by any special published code of practice. Understandably, very little emphasis has been placed on the fact that with one exception the new brands all contain 75% tobacco and are all stronger than some brands already on the market."

Mr Daube added that "inevitably, given the level of virtually uncontrolled promotional activity," wholly misleading headlines such as "safety cigarette" and "no-nicotine cigarette" had helped to create a false impression.

The ASH letter added that the marketing of part substitute cigarettes had demonstrated a signal lack of concern for public health. A press conference to launch one of the brands was held on the day following the publication of the Royal College of Physicians' latest study on the topic, *Smoking or Health*. Later, the company concerned was congratulated for its success in diluting the impact of the college report.

Mr Daube concluded that measures should be introduced to bring tobacco substitutes under the control of the Medicines Act. He said it had been estimated that the cost of advertising of part substitute brands alone would be in the region of £4 million in July. Mr Ennals was urged to insist that all advertisements for tobacco substitutes should carry the government health warning (as all tobacco and part tobacco cigarettes brands must at present); that manufacturers must be obliged to state that brands with substitutes are subject to long term human health studies; and that the percentage of tobacco in brands should be published.

Ad is back from the drawing board

EDINBURGH — A press advertising campaign containing warnings about Britain's new 25% tobacco substitute cigarettes had to be redesigned after it was rejected by the London-based Committee of the Code of Advertising Practice.

The ads featured a range of the new tobacco substitute cigarettes with the headline: "There is no such thing as a safe cigarette" and were produced by the Scottish Health Education Unit (SHEU) here. The CAP committee is believed to have rejected the SHEU advertisement on the grounds it "unfairly attacks" named products.

So SHEU re-submitted an advertisement with the same legend above a single giant "substitute" cigarette, omitting the 10 identifiable packs. This was then accepted.

The action of the CAP committee occurred only three weeks before the publication of a new stricter voluntary code of advertising practice by the ultimate advertising overlord, the Advertising Standards Authority.

The redesigned advertisement was seen by an estimated four million adults throughout Scotland. It appeared shortly before the release of World Health Organization statistics showing that Scotland tops the league of European countries for lung cancer deaths.

It's 10 pm — beware

AUCKLAND, NZ — More than one quarter of driving incidents involving alcohol or drugs in New Zealand occur between 10 and 11 pm — the hour after bars close.

Nearly three times as many incidents are detected during that period as in the hour before 10 pm, according to a ministry of transport study.

The fewest incidents are between 9 and 10 am — only 12 in 1975.

The number steadily increases to top the 100 mark in the hour after noon. The next major jump is at 4 pm, then incidents steadily pile up as the peak hour approaches. After 11 pm the number declines rapidly.

Driving incidents involving alcohol or drugs in 1975 totalled 14,448, with 3,727 of them in the peak hour.

Of the 14,448 drivers required to take breath tests, 420 were incapable of doing so at their first attempt and 547 more were in hospital.

Of the total tested, 9,973 were positive on their first test and 9,617 on their second test, 20 minutes later.

Blood-alcohol levels above the legal maximum of 100 milligrams of alcohol in 100 millilitres of blood were measured in 8,759 people, of whom 8,411 were later convicted. Those with excess blood alcohol included 1,292 aged under 20 and 46 aged over 70.

Of the 23 drivers who had more than 350 millilitres of alcohol in 100 millilitres of blood, 12 were over 50 years old.

USSR's new ale

MOSCOW — The Soviet Union, fighting the national predilection for strong spirits, has developed a beer so low in alcohol it is safe for children, the elderly, and athletes in training, the newspaper *Trud* reported.

Czechs try to tackle increasing drug problems

By John Dornberg

MUNICH — Czechoslovakia is expected to enact tougher legislation soon to deal with alcohol and drug abuse.

The action appears to be prompted by the country's rising alcoholism and drug problem.

One law has already passed the Slovak national council and has been approved by the Slovak government, though it has not yet been promulgated, presumably because similar legislation is still in the committee stage of the Czech national council where it is expected to be enacted "within the next few months."

According to federal officials in Prague, the new laws will contain stricter provisions to regulate the sale and serving of alcohol and will enhance the powers of the national anti-alcohol committees and boards which were created under previous legislation which has been in effect since 1962.

The government's role in supervising efforts to prevent alcoholism and drug addiction will also be strengthened and the Czech and Slovak administrations will be empowered to prosecute both individuals and organizations for failure to "discharge their duties" in the anti-alcohol and anti-narcotics drive.

In Prague and through Czechoslovakis . . .

The two measures, expected to be almost identical in terminology, will also provide for more detention stations, better hospitalization facilities, and outpatient treatment.

Alcohol consumption and abuse are on the increase in both regions of Czechoslovakia and the party and governmental press has recently been highly critical of the development.

The anti-alcohol boards and committees have been accused of providing "insufficient guidance" and of taking "no interest" in their work.

Personal expenditure on alcohol has risen substantially in Czechoslovakia in the past decade and at a rate far greater than total consumption of food products.

The rate of increase during the period was considerably higher in Slovakia, where wine is the national beverage, than in the Czech Lands where beer is primarily drunk.

Czechoslovak authorities are remarkably frank about admitting the societal impact of rising alcohol consumption and alcohol abuse.

In 1975, the most recent year for which statistics are available, about 30% of all people coming to trial on criminal charges had committed offences under the influence of alcohol — a total of 43,446 people.

Some 14% of all marriages, or 4,608 of them, were dissolved in 1975 because of drinking problems, compared to 2,576 in 1965.

About 20% of the children in juvenile homes are from families of alcoholics.

Drinking was the cause of 6.5% of all traffic accidents in 1975, although Czechoslovakia, like most of the East European Communist countries, has a strict ban on driving under the influence of alcohol.

Last year, according to Czechoslovak sources, the advisory centres for alcoholics treated more than 155,000 clients, although statistics given by Czechoslovak radio in December 1976 mentioned the figure of 300,000 alcoholics in the Czech Lands alone.

During the past decade, according to one official source, neurotic cases of alcoholism had increased 25% and the number of patients suffering from delirium tremens by 50%.

Although the legislation now being prepared places the emphasis on alcohol abuse, it is also directed at the drug problem.

According to one recent Czechoslovak report, consumption of painkillers, most of which can be obtained without prescription, increased fivefold between 1964 and 1974.

Ceteka, the Czechoslovak press agency, reported recently there has been a decrease in the number of known drug addicts and in narcotics-related convictions, but an increase in the number of deaths from overdose.

Nine people died in 1973, eight in 1974, 25 in 1975 and 18 last year.

Among the most frequently used drugs, according to Ceteka, are hashish, marijuana, and barbiturates. Heroin appears to play an insignificant role in Czechoslovakia.

In discussing the drug problem, Czechoslovak media invariably blame Western influences. They accuse Western tourists — but also Third World students — of smuggling narcotics into the country.

The use of hallucinatory drugs is attributed to the "bad influence of the West" and Western tourists as well as "Czechoslovak emigrees of the years 1968 to 1969 who have imported the abusive habits."

The pattern of drug-related crime in the country appears to be very similar to Western countries. There are periodic reports of pharmacies being broken into and of the theft of prescription forms from hospitals and physicians' offices.

Though no specific details have yet been made public, the legislation being prepared in Slovakia and the Czech Lands is expected to coordinate the anti-narcotics campaign.

. . . people will be facing tougher drug legislation

Conflict in roles clash

LONDON — The emergence of women's liberation as a social force may have had the unexpected result of making women more dependent on psychoactive substances.

The opinion is not, as might have been expected, from a chauvinistic male, but from a county area health education officer, Judith Waghorn.

She says in the journal of the government-sponsored Health Education Council: "Sex stereotyping has a conflicting influence on behavior in mental illness. The male learns to assume the attributes of strength and independence, which deters him from admitting weakness, particularly of an emotional nature.

"Conversely, women have hitherto been socialized to a weaker dependent role, but modern society now expects her to adopt an independent role. It is when these two roles clash that so often causes the conflict and stress which leads her to seek escape through the taking of psychoactive substances.

Ms Waghorn notes about 50 million prescriptions for psychoactive drugs are dispensed annually in England and Wales and from 1961 to 1971 this number increased by about 50%.

She reports a small survey of patients prescribed psychoactive drugs by their doctors which revealed 77% were women and 23% men. Their ages rose from a minimum during adolescence to a maximum between 40 and 50 years, after which there was a decline with increasing age. The most common complaints presented by the patients were: pain, 24.76%; depression, 22%; sleeplessness, 15.24%; physical disability and irritability, 6.67%; bereavement, family quarrels, and conflict with working colleagues, 5.71%.

The most common diagnoses made by the family physicians were: depression, 39.05%; problems of menopause, irritability, bereavement, and family quarrels, 7.62%; and sleeplessness, 4.76%.

It was apparent from the study mental illness is still disguised by physical presentation and women in the sample take more than twice as many psychotropic drugs as men.

Ms Waghorn concludes this must only reflect that men and women resort to different ways to relieve their mental and emotional problems.

"Some people find their solution to problems in a medicine bottle, others in a pint tankard or a packet of 20 (cigarettes), but the solution may sometimes prove to be yet another problem," she says.

Around the World

Med courses

British pharmacists want to be given courses in basic medicine to enable them to diagnose illnesses. Pharmacists are suggesting they be allowed to keep patients' records, and the Pharmaceutical Society is asking the government health department to include pharmacists in the yellow card system for reporting adverse reactions to drugs.

New controls

Mexico has tightened controls on retail prices of pharmaceutical products and ordered lower ceiling prices for 145 basic pharmaceutical products ranging from vitamins to tranquillizers. The tightening came in response to recent sharp and allegedly illegal price increases. Under the government's order to tighten controls, the ministries of commerce, and health and welfare will coordinate registration of new products for the purpose of setting retail ceiling prices.

Young smokers

More than 62% of West German teenage girls have smoked cigarettes, according to the Ministry of Health. Nearly half of those questioned in a survey smoked at least one cigarette before their 14th birthday, and the reasons given were primarily "boredom" and "habit." Only 5% said they smoke at home, 44% indicated they smoke at parties, and 32% in their "favorite hangout." They worry about their habit, however. Some 54% worry about health effects, and another 49% fear they may become addicted.

Glue fad crossing Atlantic?

GLASGOW — Doctors and health workers here now fear that just as Britain has followed North American trends with the major addiction problems, so too will it do with solvent abuse.

"Increasingly we are witnessing children intoxicated with glue and I feel we will need a major health education effort to get on top of the problem," Ellen McIntyre, clinical co-ordinator for the Greater Glasgow Health Board, told **The Journal.**

Dr McIntyre first became aware that sniffing was becoming established in Scotland's major city last spring when she had a telephone call from a health visitor about a 13-year-old boy who was completely addicted to a common brand of glue sold in tins.

Inquiries revealed he was one of about a dozen young male teenagers who had been playing truant from school for "sniffing" parties. The tell-tale signs included a score or more empty glue cans in the grate of a fireplace in a derelict house.

The boy was twice found unconscious on the street and medical examination showed he was already suffering some liver and kidney damage.

Within 24 hours, Dr McIntyre received another call — this time from a teacher who said he had knowledge of glue sniffing parties involving 15 young boys. A third call reported glue sniffing in an even larger group.

A working party to examine the problem was set up at the University of Glasgow's Royal Infirmary.

"We agreed to establish a register of children who had been found intoxicated with glue on three occasions and this now contains 250 names," Dr McIntyre said.

"But I am convinced it is only the tip of the iceberg. I have no doubt the problem is occurring in the socially deprived areas of other major cities too. One of the worrying things is that we are now seeing even younger children who have been to glue parties, the eight- and nine-year-olds. We have produced a booklet of guidance for teachers and social workers, district nurses, and family doctors so the problem can be recognised and caught early," she said.

Dr McIntyre is anxious, however, that glue sniffing should not be seen as an isolated problem.

"Essentially it is part of a wider social pathology," she said. "Youngsters at risk are those from socially deprived families, affected by marital breakdown, alcoholism, and so on.

Heroin on rise in Israel

TEL AVIV — Heroin has appeared for the first time in quantities in Israel, according to the Annual Police Report for 1976. It goes on to note that 215 grams were confiscated in 1976, as compared to "nothing" in 1975.

Together with the appearance of heroin, the report says the number of "pushers" has increased by 50%, from 106 in 1975 to 160 in 1976.

Moreover, if the quantity of kilograms of opium confiscated has dropped from 10 kilograms in 1975 to two kilograms in 1976, the number of kilograms of hashish confiscated has increased from 271 in 1975 to 612 kilograms in 1976. Also, for the first time, the police report notes marijuana has been confiscated — if only two kilograms.

New Books

by RON HALL

The Effectiveness of Drug Abuse Treatment Volume V: Evaluation of Treatment Outcomes for 1972-1973 DARP Admission Cohort

. . . edited by S. B. Sells and D. Dwayne Simpson

This fifth book in the series of volumes based on the Drug Abuse Reporting Program (DARP) reports the evaluation of year four admissions based on a modified version of the research design described in earlier volumes. Effectiveness of treatment for large and diverse samples of patients is provided and further research on treatment program classification is described.

(Ballinger Publishing Company, 17 Dunstar Street, Harvard Square, Cambridge, Massachusetts, 02138. 1976. 560p. $25.)

Here's How To Sobriety

. . . by Luther and Eileen Lord

This illustrated book presents information dealing with facts about alcoholism, why meetings are important to sobriety, and attitude changes involving self-honesty, self-forgiveness, and finding a power greater than the bottle. The book encourages those who need help to seek help and explains why group meetings, such as Alcoholics Anonymous, are important to the recovery process. The reader is also made aware that attitudes toward the use of chemicals and toward life can be constructively changed.

(Hazelden Books, PO Box 176, Center City, Minnesota, 55012. 1977. 107p. $2.95.)

Other Books

The Biology of Alcoholism — Kissin, Benjamin, and Begleiter, Henri (eds). Plenum Press, New York, 1976. "Volume 4: social aspects of alcoholism;" alcohol use in tribal societies; anthropology; drinking behavior and problems; alcohol and youth; alcohol and the family; alcoholic personality; alcoholism and mortality; crimes of violence; injury; employment; education; legal restraint. 643p. $43.10.

The Heroin Epidemics: A Study of Heroin Use in the United States, 1965-75 — Hunt, Leon Gibson, and Chambers, Carl D. Spectrum Publications, Inc, New York, 1976. Incidence of new users; prevalence; treatment and prevention; appendexes. 145p. $13.95.

Bad Trips. Freakouts, Overdoses: Emergency Treatment of Drug Crises — Health and Welfare Canada, Ottawa, 1976. 45p.

Studies of the effectiveness of treatments for drug abuse. Volume V: Evaluation of Treatment Outcomes for 1972-1973 DARP Admission Cohort — Sells, S. B., and Simpson, D. Dwayne (eds). Ballinger Publishing Company, Cambridge, 1976. Figures; tables; index. 522p. $17.50.

Psychoactive Drugs and Social Judgement: Theory and Research — Hammond, Kenneth R., and Joyce, C. R. B. (eds). John Wiley and Sons, Toronto, 1975. Problem; theory; method; empirical studies; new directions; indexes. 278p. $18.25.

Physiological Disposition of Drugs of Abuse — Lemberger, Louis, and Rubin, Alan. Spectrum Publications, Inc, New York, 1976. Principles of drug distribution; amphetamine; mescaline; LSD; morphine; barbiturates; caffeine; nicotine and alcohol; cannabinoids; cocaine; tolerance; index. 401p. $29.50.

Behavioral Pharmacology: The Current Status — Weiss, Bernard, and Laties, Victor G. (eds). Plenum Press, New York, 1976. Environmental influences affecting voluntary intake of drugs; interactions of behavioral and neurochemical processes; behavioral toxicology; reinforcement as determinant of drug response; index. 301p. $45.45.

Behavioral Treatment of Alcoholism — Miller, Peter M. Pergamon Press, Toronto, 1976. Assessment; aversion therapy; teaching alternative behaviors; operant approaches; marital interaction; controlled drinking; indexes. 188p. $6.60.

Alcohol: The New Teen-Age Turn-On — Blakeslee, Alton, and Sullivan, Brian. Associated Press, New York, 1975. Society; reasons for drinking; peer pressure; law; education; research; treatment. 38p. $1.25.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

See How They Run

Subject Heading: Sports and drug use: etiology and epidemiology.
Details: 26 minutes, 3/4" videocassette, color, sound.
Synopsis: An examination is made of the role and control of drug use in sports. Interviews with experts, team doctors, coaches and players are conducted to demonstrate the use of various drugs characteristic in different sports and their associated dangers.
General Evaluation: Poor (2.0).
Recommended Use: Although this videotape seemed to be designed for coaches, athletes, and general audiences of 15 years of age and older, the AV Assessment Group does not recommend its use.

Psychoactive

Subject Heading: Drugs, pharmacology, drug use, etiology, and epidemiology.
Details: 28½ minutes, 16 mm, color, sound.
Synopsis: The film illustrates how the nine body systems work together to help a human body function normally. Unfortunately, many people turn to self-medication in the hopes of changing the functioning of one or more of these body systems. The effects of tranquillizers, hallucinogens, stimulants, and depressants on the human body are presented, and withdrawal, tolerance, and dependence are discussed.
General Evaluation: Good to very good (4.5).
Recommended Use: Audiences of 12 years of age and older. Especially useful for the professional development of those entering drug-related fields.

It Was A Good Day

Subject Heading: Alcohol, attitudes and values.
Details: 12 minutes, 16 mm, color, sound.
Synopsis: A young man, competent at outdoor living, enjoys a canoe trip, fishing, and seeing animals in their natural setting. In a rain storm, he takes shelter and drinks whisky. His outdoor living skills disintegrate. He wakes up the next morning with a hangover, and is no longer able to appreciate the things of nature that he loved the day before.
General Evaluation: Fair to good (3.7).
Recommended Use: Audience of 12 years of age or older.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

21st annual meeting of the American Association of Automotive Medicine — Sept 15-17, 1977, Vancouver, British Columbia. Information: Traffic Injury Research Foundation of Canada, 1765 St Laurent Boulevard, Ottawa, Ontario, K1G 3V4.

Detox Training Program — Sept 26-30, Oct 24-28, 1977, Addiction Research Foundation, Toronto, Ontario. Information: Diane Hobbs, ARF, 33 Russell Street, Toronto, Ont, M5S 2S1.

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

20th annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario. M2K 2R9.

Actionplan '78, 13th annual conference of the Canadian Addictions Foundation — Sept 19-25, 1978, Calgary, Alberta. Information: CAF, 303 Kendall Street, Vanier, Ontario, K1L 7S7.

United States

International Symposium on Marijuana — Sept 10-12, 1977, Baltimore, Maryland. Information: Maryland Drug Abuse Research and Treatment Foundation Inc, 222 East Redwood Street, Baltimore, MD, 21202.

Alcohol and Drug Problems Association of North America annual meeting — Sept 25-30, 1977, Detroit, Michigan. Information: ADPA '77, 755 Big Beaver Road, Suite 2018, Troy, Mich, 48099.

National Alcohol and Drug Treatment Outcome Evaluation Conference — Sept 26-27, 1977, Nashville, Tennessee. Information: Linda C. Sobell, director, Alcohol Programs, Dede Wallace Center, PO Box 40487, Nashville, TN, 37204.

1st National Leadership Training Institute on Women and Alcoholism — Oct 3-6, 1977, The American University, Washington, DC. Information: Jan DuPlain, director, NCA Office on Women, 1925 North Lynn Street, Arlington, Virginia, 22209.

Empirical Approaches to the Treatment of Alcohol and Drug Abuse — Oct 13-15, 1977, Charleston, South Carolina. Information: Catherine Young, department of psychiatry, CSB, Medical University of South Carolina, 80 Barre Street, Charleston, SC, 29401.

6th annual meeting of the Association of Labor-Management Administrators and consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

Perspectives in Psychiatry . . . the 1980s and Beyond — Oct 27-28, 1977, New York City. Information: Dean of the Clinical Campus, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York, 11040.

National Community Action Agency — Oct 29-Nov 3, 1977, Philadelphia, Pennsylvania. Information: Together Inc, PO Box 52528, Tulsa, Oklahoma, 74152.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, Do It Now Foundation, PO Box 5115, Pheonix, AZ, 85010.

2nd Southeastern Conference on Alcohol and Drug Abuse — Dec 1-3, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC '78, 200 Broadway, Seattle, Wash, 98122.

Joint Conference of the American Association for Automotive Medicine and 7th International Association for Accident and Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

Abroad

9th Summer School on Alcoholism — Sept 10-16, 1977, Brighton, England. Information: The Secretary, Summer School on Alcoholism, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, SE5, 8AZ.

Workshops on Alcoholism in Scandinavia — Oct 4-18, 1977, Denmark, Norway, and Sweden. Information: New York City Affiliate Inc, National Council on Alcoholism, 730 Fifth Avenue, New York, NY, 10091.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Swtizerland.

Special Symposium on Drug Dependence, 11th International Conference on Pediatrics— Oct 23-29, 1977, New Delhi, India. Information: Dr O. P. Ghai, All-India Institute of Medical Sciences, New Delhi, India.

Asian Seminar on Research and Epidemiology on Drug Dependence — Nov, 1977, Chaing Mai, Thailand. Information: Professor Prasop Ratankorn, director, Drug Dependence Research and Prevention Centre, 268 Rama 6, Phyathai, Bangkok 4, Thailand.

3rd Arab International Conference on Alcoholism and Drug Abuse — Dec 3-7, 1977, Khartoum, Sudan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th Colombo Plan Consultative Committee Meeting — Dec, 1977. Information: The Colombo Plan Bureau, 12, Melbourne Avenue, Colombo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

International Conference on Alcoholism and Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute on the Prevention and Treatment of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Cast Postale 140, 1001 Lausanne, Switzerland.

24th International Institute on the Prevention and Treatment of Alcoholism — June 25-30, 1978, Zurich, Switzerland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence -- Sept 3-8, 1978, Warsaw, Poland, Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

CDOs - a way to refine the system

Martha Sanchez-Craig

In this special article for **The Journal**, *Martha Sanchez-Craig presents her suggestions for the reformulation of the present treatment system for the public inebriate.*

Dr Sanchez-Craig, a psychologist, is director of the Addiction Research Foundation of Ontario's Spadina Project, a halfway house for male and female alcoholics.

She writes: "There is general agreement that a systematic and satisfactory program for dealing with the public inebriate does not now exist. When the concept of non-medical detoxication centres/halfway houses was enunciated and developed, hopes were high this would provide the answer. In retrospect, such hopes were not well founded. In my view, however, most of the criticisms which have surfaced around the system have to do with the manner in which it has been utilized. What seems to be necessary is to place it in a context which will permit its optimum utilization."

Some alcoholism workers believe public funds should not continue to be invested in the system adapted by the Ontario government for the rehabilitation of the chronic public inebriate. Before 1970, public drunkenness was considered an offence in Ontario and was handled through the legal system, i.e. arrest, trial, and at times, incarceration. The new treatment system for the chronic public inebriate, which is composed of non-medical detoxication centres and halfway houses, was intended to be a more humane alternative to incarceration.

Bill 101 empowered the police to bring public inebriates to detoxication centres, the objectives of which are to achieve the short-term rehabilitative goal of stabilizing their clientele and inducing them into a longer term treatment process. Halfway houses were established for this purpose. In a period of from three to six months, these facilities are expected to return their clients to the community with their drinking under control and their life style stabilized into a more normative pattern.

The Task Force II Report on the Ontario Detoxication System (1976) summarized a body of data which demonstrated the program was failing to meet its objectives in the following important respects: (1) a large proportion of detox admissions during the year preceding the report were not chronic public inebriates. More than 50% of the detox beds were used by people with stable accommodation and family ties, characteristics which are not usually found in chronic public arrestees; (2) the majority of chronic public inebriates continued to be dealt with through the legal system. Where detoxication centres had been established in the province, on the average only 25% of police arrestees were taken to those centres; (3) staff of detoxication centres were able to persuade less than 10% of first admissions to enter long-term treatment. The rate of successful referral decreased for second and subsequent admissions; (4) halfway houses and other facilities failed to retain clients in treatment. Only 26% of the halfway house clients stayed more than three months, and most left before six weeks. Similarly, out-patient clinics typically failed to retain chronic public inebriates beyond a second appointment.

Criticisms of the system all concern its failure to attract and retain its designated client population. Although, from the public health point of view, it is undoubtedly desirable to persuade chronic public inebriates to modify their life style, it may be simplistic to expect that most members of this population will successfully embrace middle class norms and practices, especially in as short a period of time as three to six months (the expected length of stay in halfway houses).

Then the question to ask is: Are there acceptable and economically feasible treatment goals which might attract into treatment and retain a substantial proportion of this population? Before the response to the chronic public inebriate is abandoned it would be wise to consider more circumscribed, but not necessarily less appropriate treatment goals than those now in force.

I intend here to suggest a reformulation of the present system, which should permit its optimum utilization, and prove to be more attractive to the target population. In making this reformulation I adopted two criteria which I felt were important:

1) that demands not be made for the opening of new facilities. The system should utilize only those resources which are already available in the community.
2) that the reformulation be based on empirical evidence and not speculation.

Briefly, the reformulation is as follows:

Overall Objective

I believe the mandate for the detoxication centres and halfway houses to rehabilitate *all* public inebriates is unrealistic. A more feasible objective for the system could be stated as follows: To provide *care* to all public inebriates and rehabilitation *only to those* who have the physical and psychological structures required to achieve rehabilitative goals, and the motivation to get involved in a program of rehabilitation.

Resources

These will continue to be the police, the detoxication units, and the halfway houses or recovery homes.

• Detoxication centre — The initial point of contact between the public inebriate and the care-rehabilitation system will be the detoxication centre. This is a far more economical point of entry than the hospital or the jail and manages to avoid the "criminal" or "sick" stigmatization of the client.

The main purpose of this facility will be to remove the public inebriate from the street and *care* for him or her temporarily in an alcohol free setting. Demands for rehabilitation *will not* be placed at this level since the majority of clients are simply not prepared physically, psychologically, or motivationally, to consider rehabilitative goals.

A summary statement in the Task Force II Report reads as follows: "Attitudes of current skid row alcoholics suggest that detoxication centres are seen primarily as drying-out and care-taking agencies rather than as gateways to rehabitation". The role of staff in detox will be to care for their clientele while drying out, and to provide them with information regarding community resources that could be used if they become interested in changing their life style.

Effective implementation of the new system will require that detoxication centres be used by chronic public inebriates. Recommendation #1 in the Task Force II Report, therefore, ought to be implemented. This recommendation reads in part, as follows: ". . . . that admission to a detoxication unit be reserved primarily for chronic drunk arrestees who are largely lacking in other support systems".

• Halfway house and needs assessment — The halfway house will be organized in two stages or levels which could be implemented in a single facility, or in two separate facilities. For this discussion, I will refer to the first level as House I, and to the second level as House II.

The objective in House I will be to provide a supportive environment, for an extended period of time, to permit recuperation from the adverse effects of alcohol use. There will not be a demand for *total* rehabilitation. Clients will be expected to maintain their drinking under control, to develop habits which contribute to their personal health, and to assist in the running of the home. Low key surveillance regarding the clients' motivation for further rehabilitation could be introduced at this level.

Clients in the detoxication centre who express a need to stop drinking for medical reasons, or because they wish to change their life style will be eligible for this facility. In light of Maslow's theory, it may be assumed that once clients have an opportunity to satisfy their basic needs (e.g. to be fed, clothed, and sheltered), and to recover from the extensive use of alcohol, a need to pursue more comprehensive rehabilitative goals may arise. When this is the case, a needs assessment will become necessary to determine whether rehabilitation is feasible, the extent to which it is feasible, and the sort of interventions that will be necessary.

If, according to the assessment, more comprehensive rehabilitation is feasible (e.g. vocationally, socially, and recreationally), the client will be eligible for House II. The primary goal in this facility will be to assist the client in the achievement of goals which will permit him to function productively in his community. Such rehabilitation might be produced either by a program indigenous to the home itself, or by connections with other agencies, or by both. In order for the client to maintain his residency in House II, he has to conform to the drinking policies of the house, follow the house rules, and continue to show motivation and progress in the achievement of goals.

When the assessment indicates the rehabilitation of a client is improbable (e.g. on account of extensive damage due to alcohol), the client could remain in House I as long as he continues to function well in that environment, or he could be referred to longer-term domiciliary care. It is expected that a proportion of the clients in House I will, after some time, achieve a reasonable state of health, but will not be interested in pursuing further rehabilitation.

Since there is little point in attempting to rehabilitate individuals who do not wish to be rehabilitated, I believe the system should continue to take care of them provided they keep their drinking under control, and behave in agreement with the expectations of the home.

But why should the system take care of people who have the potential to function productively? The answer is they do not function productively, and as long as they continue to be "revolving door alcoholics" they will be a drain on public resources such as hospitals, courts, jails, and the welfare system. It is an empirical question whether the proposed system will constitute a greater cost. At least, it has the potential for allowing this group of people to live with dignity.

There are several advantages to this proposed system. A humane and reasonable set of options is offered for the chronic public inebriate. Unrealistic demands for commitment to overall rehabilitation are not made but the possibility of attempts at rehabilitation when the client is ready exist in the system. Operating as it would, entirely outside a hospital or jail context, the system may be very economical. In addition, because more realistic objectives would be established than hitherto, much of the frustration and anguish that has accrued in dealing with the public inebriate might be removed.

THE BACK PAGE

Clash brewing on secret drug files

By Bryne Carruthers

OTTAWA — The more than 163,000 Canadians listed in secret federal health department files as "known cannabis users" in Canada have the right under recently passed human rights legislation to know whether the files exist, to see what's in them, and to correct information which might be wrong or misleading.

That is the view of Gordon Fairweather, former federal member of parliament for Fundy-Royal, and now Canada's first commissioner of human rights.

But it is not a view shared by the federal Health Protection Branch and the federal Bureau of Dangerous Drugs in Ottawa which keep the drug users' files.

And there is a growing chance that the drug file controversy, first uncovered by **The Journal**, (September) could become the focus of the first real test of the federal governments' willingness to open up secret personal files to the affected Canadians under the prodding of the privacy provisions of the Human Rights Act.

Interestingly enough, the health department has already showed signs of moving to head off such a confrontation.

The department has now decided that individuals suspect-

(See — BDD — page 7)

The Journal

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Ali scraps talk switches to God

Muhammad Ali

By Dorothy Trainor

MONTREAL — World heavyweight champion Muhammad Ali (Elijah Muhammad) attended the Second World Conference of Therapeutic Communities, held in Montreal, "to bring a message from the American Muslim spiritual leader Wallace Muhammad of Chicago."

But the message must have left some of the 300 delegates from around the world somewhat disconcerted: Ali had been scheduled to talk about his personal involvement with drug rehabilitation programs, but instead gave a sermon — in the best evangelical tradition.

More from the TCs conference on page 6.

In his half-hour address, he mentioned drugs only in passing and said: "If you've come to this conference to listen to the advice of human beings, you're wasting your time."

The audience loved him just the same and applauded wildly as Ali lashed out at rape, prostitution, pornography, homosexuality, war, drugs, crime, corruption, etc.

"In the USA, we have the best of everything and the lowest morals. God is the only authority and no one should be asked to obey laws not made in accordance with God's wishes. Sometimes the people who are upholding the laws are more crooked than those asked to obey them."

There is only one solution to the world's problems, he said: "Get people back to God, study the scriptures, follow what God says, or you're just meeting for nothing!"

Alcoholics should not become pregnant

Birth pill, abortion urged for female alcoholics

By Betty Lou Lee

MONTREAL — Alcoholic women should be on birth control pills, or have free access to abortion if they do get pregnant, since 30% to 50% of their babies run a real risk of fetal alcohol syndrome.

And women who consume an average of one ounce of absolute alcohol a day — the equivalent of two cocktails or two beers — are putting their babies in jeopardy for at least some damage.

These opinions come from a team of researchers at the University of Washington, Seattle, the first North American centre to document the syndrome about five years ago.

The idea that alcoholics should not become pregnant comes from one of the researchers who coined the term fetal alcohol syndrome, pediatrician D. W. Smith. In an interview, he was just as adamant about the dangers of even social levels of drinking.

"The ideal is for the fetus not to be exposed to alcohol at all ... there is good evidence that the risk factor is a continuum, the higher the level of drinking, the greater the likelihood of a problem. Even two drinks a day can have a mild impact," Dr Smith said.

"My big pitch is that this is so preventable, everyone should know about it. We know the risk is clearly there in the first trimester. We aren't so sure about the second and third."

He said the woman herself is a good barometer of how alcohol is affecting the fetus. "If she's feeling how much she's had to drink, then the fetus is, too. It hits the baby at the same level. I would like to see mothering start right from conception, not just from birth, and this should be part of her concern for the baby's welfare."

Psychologist Ann Streissguth, who has been studying the development of a number of children born with the syndrome, said they range from 50 to 100 in IQ, with an average of 68, and any brain damage they suffer is irreparable.

Even placed in excellent foster homes, away from what may be the substandard care of an alcoholic mother, they do not make up their deficit.

In addition to an impairment of general growth, the brain is smaller.

A poster display from the Seattle centre also showed gross brain anomalies in some of the most severely affected babies, including complete absence of the corpus callosum, the bridge between the brain's two hemispheres.

In a study of 54 women who consumed between one and two ounces of alcohol a day during pregnancy, 11% of their babies had at least partial features of the fetal alcohol syndrome. In those who drank more than two ounces, the rate was 19%.

Dr Streissguth said it didn't seem to matter if consumption worked out to two drinks a day every day, or 14 drinks over the weekends.

The National Foundation/ March of Dimes, which sponsored the Fifth International Conference on Birth Defects, introduced a new informational pamphlet titled "When you drink, your unborn baby does, too!"

It says that no one knows how much alcohol is too much, and that "alcohol and pregnancy don't mix".

A mouse model for fetal alcohol syndrome, developed at the University of British Columbia, indicates damage to the fetus may depend not on how much the mother drinks, but the amount required to reach a certain blood alcohol level, and this in turn is dependent on a genetic factor.

Dr G. F. Chernoff of the department of medical genetics used three different strains of mice, and found they differed in their sensitivity to alcohol.

American doctors may yet 'scream loud'

US could still cultivate bracteatum

By John Shaughnessy

TORONTO — The United States government is keeping its options open on the commercial cultivation of *Papaver bracteatum*.

This summer, the government announced it would not permit cultivation of the plant (**The Journal**, July). But, according to Donald E. Miller, deputy administrator of the Drug Enforcement Administration, the decision does not mean the *bracteatum* issue is closed.

At the meeting here of the International Narcotic Enforcement Officers Association, Mr Miller said "if there's a thebaine shortage sometime in the future, the American medical profession is going to be heard screaming loud and clear, and we would probably be forced to go into the production of *bracteatum*."

Mr Miller made his comments after Dr George Ling, director of the division of narcotic drugs at the United Nations, and Dr Donald Smith, senior scientist in the International Health Office for Canada's department of health and welfare, had publicly thanked the United States government for its "responsible and responsive" decision to prohibit cultivation of *Papaver bracteatum* within its borders.

(*Papaver bracteatum* has a high yield of thebaine which can be used to make several narcotic drugs, particularly codeine. Most codeine is currently processed from the opium poppy, *Papaver somniferum*, which has only about 2% thebaine.)

Mr Miller conceded that the current worldwide requirements for the production of codeine can be satisfied with available sources of opium poppy, but he pointed out that researchers may develop other drugs requiring thebaine.

"It's going to be the responsibility of the United Nations division of narcotic drugs and the International Narcotics Control

(See — Thebaine — page 7)

Inside

'Even the US President thinks it's safe'

We've all been misled on cannabis, say law officers

By John Shaughnessy

TORONTO — Changes in marijuana laws throughout North America are creating concern that a false impression is being given that the drug is harmless.

And the impression is shared by youth, the middle class, high government officials, and even the president of the United States, according to officials at the meeting here of the International Narcotic Enforcement Officers Assocation.

Members of a panel discussion on marijuana were unanimous in the view that decriminalization laws recently enacted in the US had been passed without proper consideration of the medical and social risks involved in marijuana use.

They felt the new laws were the result of "propaganda campaigns" waged by such pro-marijuana groups as NORML (National Organization for the Reform of Marijuana Laws) and apathy or reluctance on the part of the scientific community to bring forward evidence of the real and potential dangers of the drug.

Clinton Hayward, Jr, chairman of the Maine Chiefs of Police Association subcommittee on marijuana decriminalization, said Peter Bourne, director of the now threatened Office of Drug Abuse Policy (**The Journal,** September) "has repeatedly and consistently failed to fulfil his obligations by refusing to inform the American public, and more importantly the president, on the harmful effects of marijuana.

"Bourne, who has been advocating decriminalization for years has ignored the available medical information in favor of the position being espoused by NORML and its director, Keith Stroup. President Carter, who is now promoting the pro-marijuana philosophy, is very obviously a victim of mis-information on the part of Mr Bourne."

In addition, Mr Hayward charged that Dr Bourne had intentionally misled the American public with statements relevant to the increases in marijuana use in Oregon following decriminalization. "His statement that the increase was only about 5% was arrived at after averaging all age groups together, and nowhere suggests that there was a 35% increase in the 18-29 age group which was the case."

In Maine, there has been a steady and dramatic increase in the abuse of marijuana, according to Mr Hayward. In his own community of Calais, he has found about a 40% increase in the number of seizures and anticipates it could reach 100% after the figures for the tourist season have been tallied.

"Since many agencies and communities in the state are processing no marijuana cases at all, some statistics for the state suggest there has been a 35% decline in the number of marijuana cases since decriminalization while we know that abuse of the drug has increased by a similar figure," said Mr Hayward.

He said one of the major problems accompanying widespread use is the hazard being created on the highways by the driver "high on grass" while no suitable and economical test has yet been developed which could assist the patrol officer in combating this menace.

More conference news page 6.

"A study recently conducted in Boston indicates that 16% of fatal accidents are associated with the marijuana smoking driver, and I believe similar results would be forthcoming from studies done anywhere in North America."

Another danger, according to Mr Hayward, is that the campaign to decriminalize and legalize marijuana is giving the drug an unwarranted "good housekeeping seal of approval" as a harmless substance and is part of a larger and increasingly urgent propaganda effort to legalize all dangerous drugs from hash to heroin, "which history has shown would be a disaster for America."

George C. Bendt shared Mr Hayward's concern about the campaign to legalize all dangerous drugs. He said in Minnesota marijuana was decriminalized following heavy lobbying from pro-marijuana groups but with little or no input from police and other opponents of liberalized marijuana laws. The results, following decriminalization, have been similar to those Mr Hayward described in Maine, he said.

Mr Bendt, supervisor of the narcotic squad for the Minneapolis Police Department, also noted that about two years ago the state bar association set up a committee, chaired by Marc G. Kurzmann, to look into the decriminalization of all controlled substances.

Eighteen months later the Metropolitan Area (Minneapolis-St. Paul) Narcotic Enforcement Officers and Treatment Personnel became aware of the committee's existence, and set up their own committee to refute what they considered to be errors and misleading impressions in the Kurzmann report which advocated decriminalization.

"So far we have been successful in getting the state bar association and various legislative committees to reject the Kurzmann report," said Mr Bendt. "But our struggle is not over. Next year we expect Mr Kurzmann to make an effort to get cocaine decriminalized."

Both Mr Hayward and Mr Bendt are convinced the continuation of these drug promotion campaigns could have disastrous results. They say the drugs being heavily promoted have either already been proven to be, or are considered to be, potential health and/or social hazards by responsible authorities.

The main points being made in the pro-marijuana propaganda and lobbying campaign, according to Mr Hayward, are that these drugs are essentially harmless; that only a small minority will become drug abusers if drugs become available; and that attempts by police action to curb drug abuse are "both impossible and a terrible waste of taxpayers' money — legalizing use is the only solution."

Pros may be part of problem hoping for happy endings

HAMILTON — Professionals working in the addictions field are in constant danger of being part of the problem rather than the solution, says the president of the Addiction Research Foundation of Ontario.

"People who treat (addictions) have a need to feel their efforts are worthwhile. They rely on examples of happy endings, and are reluctant to seek or examine objective evidence," John B. Macdonald told the 18th annual Institute on Addiction Studies held at McMaster University here by Alcohol and Drug Concerns, Inc.

He referred to the Edwards study from Maudsley Hospital in London, (**The Journal**, Aug) which showed no difference in outcome between a group of 50 married alcoholic men with drinking problems who received a whole range of treatments, and a similar group of 50 told it was their own responsibility to deal with their alcohol problem.

"Most organizations involved in treatment continue their practices, ignoring such findings with a faith in what they are doing which seems to approach the faith of religious conviction," Dr Macdonald said.

"Staff have a commitment to what they are doing and a conviction that its value can't be questioned . . . Professionals could all profit by a more questioning attitude, more objectivity and open-mindedness."

Dr Macdonald said other studies tend to cast doubt on the value of treatment in alcoholism, but the Edwards one was the best. Its design was "elegant, and extremely careful". It was not an argument against treatment, he said, "but we should be seeking less intensive, more economic treatment, tailored to the individual.

"In my personal view, persons suffering from this disability of drinking to unhealthy levels need what help we can reasonably give. But I don't think we're justified in providing a costly network of facilities across the province . . . In the absence of a clear-cut treatment method, there should be caution about extravagance. To be realistic, we aren't sure many can be helped."

Dr Macdonald said the task force headed by the ARF's Dr Joan Marshman which is studying treatment needs based on current knowledge, and how these needs can be integrated into the health and social services network, is expected to make its report this year. "I'd be exceedingly surprised if it recommended extravagant, costly impatient services such as some are crying for."

John MacDonald

He had been asked from the audience if there are enough centres to accommodate the homeless, chronic drunkenness offender.

"As far as the homeless are concerned, I share your view they do not respond effectively to advice that their problem is their own responsibility. Some programs based on that approach, such as Bon Accord (a farm near Elora, Ont. operated by ARF) have no evidence of any success rate with chronic drunkenness offenders that's encouraging.

An option for BC - carve off a pound of flesh

By Wayne Howell

I HAVE SOME reservations about the British Columbia government's proposal that will force heroin addicts to appear before 'evaluation boards' which will have the power to commit addicts to 'special treatment centres' for up to three years.

In the first place, since it is axiomatic that justice must not only be done, it must be seen to be done, it follows that if a provincial government is going to *give addicts the treatment* it would be in the best interests of everyone — the citizens who are paying for it, the government that is legislating it, and the addicts who are being coerced into it — that addicts not only *get the treatment* but they be *seen getting the treatment.*

With this in mind, I make the following modest proposal: the Bennett government should seriously consider keel-hauling known and suspected heroin addicts.

Keel-hauling would not deviate from the general principles upon which the proposed program appears to be based and it would have a subsidiary benefit since the keel-hauling of junkies in Vancouver harbor would be an excellent way of controlling barnacle growth on the hulls of the BC fishing fleet, not to mention the provincial ferry boats.

And there is nothing to suggest that the dragging of BC junkies under the hulls of ocean going vessels (with government inspected ropes) is any less efficacious from a treatment point of view than dragging them kicking and screaming through a never ending series of evaluation boards, addiction tribunals, and rehabilitative institutions, since it has never been demonstrated that the latter activities result in any significant net social benefit, either for the addicts or for the citizenry.

My second proposal arises out of a concern that the BC plan as envisaged strays from the principles of *community involvement* in the rehabilitative program. Community involvement has been much talked about of late (indeed it was much talked about in the previous BC administration) and I see no reason why it should be rejected out of hand, especially when it is apparent that one can allow the community to participate *without sacrificing the principles upon which the program appears to be based.*

Therefore, I make this modest proposal: the compulsory treatment program should be scrapped in favour of a general program of junkie-bashing. This would allow concerned citizens to participate in the treatment process rather than having it administered by government experts. The rules for junkie-bashing would be the same as for Paki-bashing, a now well established social interraction program on the west coat and elsewhere.

The rules, in other words, would call for random acts of personal violence against addicts whenever a citizen feels a rehabilitative mood coming on. The only objection I can see to this would be that it might be hard to identify addicts in the streets, especially in winter, and thus on occasion treatment might be meted out to those not in need of it. I cannot see that this is a serious flaw in the proposal, however, since if the public takes to bashing underfed-looking street people who are not junkies, no serious harm will be done since they probably deserve to be bashed as well, just on general principle. And surely junkie-bashing is just as effective as having the addict knocked about in a Kafkaesque quasi-medical, quasi-judicial system of compulsory treatment for a period of three years.

My third proposal arises out of humanitarian motives. Rather than pursuing the proposed course, the Bennett government should seriously consider the extracting of a pound of flesh from all addicts as an alternative. This would not be done in a vicious Shylockian manner — there would be no cardiac tissue involved. What I had in mind, was the removal, under general anesthetic, of a pound of adipose tissue from the thigh or buttock.

I admit it is doubtful this will cure the miscreant of his habit, but then there is no good evidence that three years in an institution under lock and key will produce better results. The only objection I can see to this is there will undoubtedly be certain politicians and concerned citizens who will argue that a pound of flesh is not enough.

* * *

(Wayne Howell is an Ottawa physician and freelance writer.)

Law enforcement can't work alone, says Dr Ling

By John Shaughnessy

TORONTO — There is no doubt drug abuse and its associated problems could be held in check by better legal controls both at the national and international levels, says George Ling, director of the United Nations division of narcotic drugs.

The international nature of drug offences requires the application of the principle of universality in national criminal legislation, and, above all, cooperation between governments and their police and customs authorities at the international level, he says.

In addition, Dr Ling told the meeting of the International Narcotic Enforcement Officers Association here, efforts must be made to reduce the demand in order to establish effective control programs.

"Law enforcement alone cannot have any durable impact on the illicit traffic in narcotic drugs," he said. "There must be an increasing change in the criminal justice system with respect for, support for, and investment in appropriate law enforcement activities — activities which should also embrace concomittant preventive, management, and rehabilitative programs.

"Law enforcement approaches should help the user in a manner which is beneficial not only to society but indeed to the user so that he will not return to his former pattern of anti-social behavior."

To illustrate the complexity and dimensions of the problem, Dr Ling described recent patterns and characteristics of drug abuse and misuse in several countries around the world.

He said estimates of drug use in 1976 in North America, and in particular the United States, indicate there are approximately 500,000 people who use heroin, 3-4 million who use cocaine, seven million who use amphetamines, and 22 million marijuana users.

In British Columbia, it is estimated the drug trade is the fifth largest business in the province, surpassed only by forest products, mining, tourism, and agriculture.

In South-East Asia as well as Europe, there is an increasing interest in heroin use rather than in the use of opium and morphine. This pattern is evident primarily in metropolitan areas but is spreading to rural areas and to younger age groups, he said.

In Africa, heroin is rarely used as a drug of dependence but there is an increasing use of stimulants, sedatives, hypnotic agents, hallucinogens, and synthetic opioid narcotics.

In April 1977, law enforcement authorities in Egypt arrested a group trying to smuggle seven million capsules of methaqualone into the country. The availability of the leaves of the "catha edulis" plant, known as khat, is on the increase in areas around the Red Sea and the drug is used as a stimulant, euphorant, and hallucinogen.

In Lebanon, officials report approximately 2,500 acres of opium poppies are now under cultivation in the Bekaa Valley, a tribal area which for years has been the source of illicit hashish.

There has been an alarming spread of drug abuse in various parts of Europe and seizures of opiates, particularly heroin, have increased at various Northern European airports in recent months. In 1976, heroin seizures in Europe were 130 kg higher than in the United States.

Cocaine has reappeared in the drug scene in France, Switzerland, Italy, and Portugal. The abuse of sedative hypnotics such as methaqualone and barbiturates has increased in Egypt, Pakistan, and Monaco; amphetamines continue to be used in Sweden; and in Poland the abuse of trihexyphenidyl is becoming more and more widespread.

Cannabis continues to be the illicit drug most widely abused, said Dr Ling, and it is becoming evident that drugs are being used either in sequence or simultaneously. "Multiple drug abuse has become a common pattern in many countries."

In addition to the opiate problem, most regions are facing an increase in the traffic in and abuse of psychotropic substances, said Dr Ling. In terms of weight there has been an upward trend in seizures of these substances, the main increase being in the American continent. The same trend has been noted with LSD and other hallucinogens.

Large increases in seizures of amphetamines and central nervous system stimulants are also reported in Europe, and in a number of cases it is clear an international traffic is becoming established in drugs diverted from licit sources.

To eradicate the supply of some drugs of abuse, the UN division of narcotic drugs is trying several programs in countries where the drugs originate. Dr Ling said an effective control program on opium poppy cultivation is being implemented on restricted acreages in Turkey. Under this program, the poppies are not lanced and opium is not produced. Instead the poppy capsules are delivered to a government monopoly for industrial processing into alkaloids.

George Ling

The UN/Thai crop substitution program, which started in 1972, has demonstrated the feasibility of producing new and legal crops as well as improving the harvest through better water supplies and other agricultural techniques in 30 traditional opium-producing villages in Chiang-Mai province in the Golden Triangle.

In Burma, a major source of the world's illicit opium, a five-year multi-stage UN program has been initiated to assist the Burmese authorities in agricultural development, including substitution of raw narcotic crops.

With the support of the UN, the government of Afghanistan in 1973 established a police narcotics squad known to seize illicit opium at the rate of 12 tons per year, in addition to other drugs of abuse.

Police/MD conflict needs sorting out

TORONTO — Mutual respect and communication are needed to resolve the "tremendous conflict" between doctors and police over approaches to non-narcotic drug diversion.

David Smith, medical director of the Haight-Ashbury Free Medical Clinic in San Francisco says at the street level, police and doctors "have their turf worked out. If a speed freak is wielding a knife at me I want law enforcement; if a PCP abuser is yelling and screaming and the police don't know what to do, they want me."

But Dr Smith warned delegates at the meeting here of the International Narcotic Enforcement Officers Association that unilateral efforts by law enforcement agencies to curb non-narcotic drug diversion by investigating, arresting, and prosecuting physicians could alienate the entire medical profession.

David Smith

"To begin with, the medical profession is angry and afraid because of increasing government regulation of their practices. When doctors read or hear of one of their colleagues being investigated or arrested because of his prescribing patterns, they get the idea the police are after all doctors."

To avoid this situation, law enforcement personnel should tell medical societies in a general way who they are after, why, and who they are not after, said Dr Smith.

"The medical profession wants to get rid of its bad apples as much as anyone, but they want to be sure only the bad apples are removed."

In most instances of poly-drug abuse, physicians are the source of supply for the abuser, but Dr Smith stressed the problem is not a homogeneous one.

A significant source of supply is the "script doctor" — the "easy writer" — who sells prescriptions for profit. But there are other doctors who are merely outdated in their prescribing practices and who prescribe psychoactive drugs without understanding them and without paying particular attention to their abuse potential.

Physicians prescribing medications for the treatment of addiction constitute a third group. Dr Smith said his clinic has developed a generally accepted phenobarbital regimen for the treatment of barbiturate addiction, but theoretically he's violating the law every time he uses it because barbiturate addiction is not an accepted indication for using the drug.

The problem is defining which physicians should be prosecuted, and which should be educated, said Dr Smith. A balanced approach is needed, and this can best come about when the law enforcement and medical professions cooperate.

One area where balance has been lacking is in the approach to the physician who is himself addicted. Dr Smith said current estimates suggest there are between 10,000 and 17,000 physicians in the United States with alcohol or drug abuse problems and, until recently, substantially all public efforts to deal with the problem have in one form or another involved law enforcement.

"The difficulty with this approach is that the fear of being discovered and losing the licence often leads the physician to keep his problem secret: as a result, the number of physicians being arrested represents only a small percentage of those actually abusing."

Unquestionably, the police and the therapist have different goals in dealing with an addicted physician, said Dr Smith. The primary role of law enforcement is to protect public safety. From a therapist's point of view, the loss of a licence by an addicted physician can be a major blow to his rehabilitation.

"Police and treatment personnel must work together on this problem, but in my view, the public safety aspect has been over-emphasized at the expense of the addicted physician himself," said Dr Smith.

Some programs are being developed to help correct this imbalance. In California a confidential treatment network has been set up so addicted physicians can be treated in private hospitals throughout the state. The state's board of medical quality assurance is informed of physicians being treated, but the treatment and disciplinary aspects are kept separate so there will be no risk of information, given by the addicted physician during treatment, later being used as evidence in a disciplinary matter.

'Doubtful they are carcinogenic'

Cannabinoids produce no mutation in human cells, Canadians find

By Harvey McConnell

BALTIMORE — Cannabinoids in marijuana do not cause mutation in human cells, Canadian scientists have shown.

"In my experience, and as far as I know, most carcinogens are mutagenic. Since we have found tetrahydrocannabinol, cannabidiol, and other cannabinoids are not mutagenic, it is doubtful they are carcinogenic," declares Arthur Zimmerman, professor of zoology, University of Toronto.

Dr Zimmerman carried out his research with Hans Stich, of the Cancer Institute, University of British Columbia.

He told **The Journal**: "This is the first study to show that cannabinoids are not mutagenic.

"We have shown unequivocably that cannabinoids did not induce any chromosomal aberrations, did not induce any unscheduled DNA repair, and did not induce any microbial histidine-altered Salmonella effects.

"We used a battery, and I must emphasize the word battery, of tests the National Cancer Institute uses to help evaluate mutagenic agents. Dr Stich is well known for his studies on mutagenicity, and has developed, analyzed, and evaluated a variety of methods which can be used for screeing mutagenic agents."

Dr Zimmerman, who was attending a conference here of the Maryland Drug Abuse and Treatment Foundation, said the data he and Dr Stich obtained is negative "but the significance is rather obvious" considering the vast number of people who smoke marijuana.

Although he is engaged in a number of research projects at the University of Toronto, Dr Zimmerman took part of a sabattical year to work with Dr Stich on the tests using human fibroblasts and Salmonella organisms.

He explained: "These are conservative tests done by experts, and this is most important. You must conduct these tests with a background of knowing what you are doing: one cannot just learn these things and do them in your own laboratory.

"This is why I went to British Columbia because Dr Stich does these tests routinely and he has no bias."

Five tests, which were replicated, were used by Drs Zimmerman and Stich and special activating enzymes were used as well as the non-activating procedure.

Dr Zimmerman said: "We use activating enzymes on the assumption THC and the other cannabinoids may be what are called pre-carcinogens. These are a series of chemicals which, under normal circumstances, do not elicit mutagenic effects. In the body, however, the liver, testes, or other organs have enzymes which can change the inner chemical into an active carcinogen.

"We found that activation did not cause any mutation." A chemical may be mutagenic but it goes not mean necessarily it is carcinogenic. But, "if it is not mutagenic, it is improbable it would be carcinogenic."

While he thought the results of the non-activated test procedures would be negative, Dr Zimmerman "had a feeling activating a metabolite of THC might induce it. To my surprise it had no effect." The full results of the research are to be published shortly.

US heroin for cancer?

WASHINGTON — Permission to have pure heroin used to relieve pain in patients with terminal cancer may be sought by Arthur Upton, director of the United States National Cancer Institute.

Such a procedure could be similar to that which is routine in Britain: hospital doctors can administer heroin when other drugs become ineffective in the relief of pain.

Dr Upton said he plans to discuss with federal officials the possibility of using medically pure heroin. Some 375,000 Americans a year die of cancer.

He added that where it is possible to relieve unnecessary suffering he would like to be able to do so.

Addiction is characteristic of user, not of drug

Betty Lou Lee reports from the 18th annual Institute on Addiction Studies at McMaster University, Hamilton

ADDICTION IS a characteristic of the drug user, and not the drug itself, says psychologist George Blake, director of the Pinewood Centre at Oshawa General Hospital.

"As long as we persist in defining addiction as a characteristic of drugs, we will never understand or be able to deal with drug abuse," he said.

"Conceptually, in our mind, and practically, it is important that we begin to think of addiction as a characteristic of a person, of his or her way of dealing with life.

"The fact that as part of dealing with life a person may choose to use narcotics, alcohol, barbiturates, tobacco is just that, a lifestyle choice. It does not make addiction a characteristic of the particular drug. Individuals who experience a tremendous withdrawal phenomenon when they stop smoking are as much exhibiting an attitude to life as well as any effect that nicotine may have on their bodies," he said.

What the person is addicted to, Dr Blake maintained, is the experience the drug creates for him, and what is needed to neutralize addiction is a change in life style, and the ways of interpreting life's experience.

If the drug relieves anxiety or stress, and decreases capability so stress-producing situations appear less severe, the user is likely to become addicted to the stress-relief experience.

Dr Blake said reactions to drugs are influenced by social groups, cultural attitudes, personal choice, and expectations: a drug considered dangerous and uncontrollable in one society may be viewed as harmless or beneficial in another.

In North America, the large supplies of over-the-counter drugs in many homes create a cultural atmosphere of looking for relief at the first sign of discomfort. Every scratch gets a bandage.

"I suspect that largely, the drug culture is an extension of the cultural attitude to coping with and managing stress."

On the question of easing marijuana laws, Dr Blake suggested while information about the effects of cannabis is unclear," it would seem that the wise choice is to err on the side of caution, rather than reckless liberalization of laws and the lifting of controls."

In the drug culture, there is a conflict between individual rights and freedom, and social responsibility.

"It is questionable whether an individual has the right to injure himself with drugs, if in so doing he places or becomes a burden on his community. In such a case, the individual is meeting his needs at the expense of others. This is privilege without responsibility, a situation which the community has the right to protect itself against in order to preserve its institutions, welfare, health, and development."

Alcoholic needs a crisis to move him and a friend along the road to recovery

AN ALCOHOLIC who has wrapped himself in a blanket of rationalization and denial, and has managed to involve everyone in his life in his protective games, won't even consider changing his behavior without a crisis that threatens this protection.

"He will not begin to consider this possibility until some significant area of his life becomes so uncomfortable and the discomfort can be related to his drinking, that he is either forced to reconsider his drinking habits, or remove himself from the uncomfortable situation, such as leaving his job or family," according to Sarah J. Saunders. Dr Saunders is medical consultant to the Metropolitan Toronto Region of the Addiction Research Foundation.

Any crisis will do, but constructive threats of job loss or loss of protection by the spouse are the commonest.

Dr Saunders said the alcoholic cannot change in isolation: "He needs the help of another person as he begins to sort through the maze leading to recovery" — and that helper can be anyone, professional therapist, AA member, friend.

However, the helper must avoid being drawn into the protection game that the alcoholic has become so adept at playing as he got his wife to tell his boss he had the flu, his fellow workers to punch the clock for him, his doctor to write sick-leave certificates for gastritis.

As the helper provides support, he should help the alcoholic assess all problem areas (medical, psychiatric, family, socializing and recreational skills, employment, spiritual, legal, and financial) and develop a treatment plan that resolves the problem areas the alcoholic, not the therapist, sees as most crucial.

The helper's support must continue through whatever treatment plan the two work out — usually a minimum of 18 months, she said. "He desperately needs a person he can trust as he begins to explore the multiplicity of changes that he must make. Only by exploring change possibilities in such a situation can he then develop the courage to try his new way of life in the world at large."

She said the big problem with the two traditional approaches to alcoholism was that the concept of its being morally wrong left the victim to deal with it by himself, while the disease concept placed the onus for recovery on a therapist, the doctor curing the disease.

There are nine steps to recovery, Dr Saunders said, many of which will have to be repeated several times, and their order will vary with the individual. The person must acknowledge there is some sort of problem, that it's directly related to alcohol, that it's big enough for a consideration of change to be worthwhile, and that some change possibilities exist.

Life must be so disastrous that change will be risked even though the outcome is unknown, and there must be trust in another person. There must be a relatively safe environment in which to explore these changes, a testing out of changes in the real world, and a safe environment to return to for further work when the changes don't work at first.

Sarah Saunders

That safe environment can be anything from the relationship with a friend to a formal treatment centre.

One mistake therapists often make, she said, is to assume that when an alcoholic appears for help, he is ready to explore change possibilities.

"In actual fact, he more frequently is just beginning to acknowledge that he has some problem in his life, and he may or may not be connecting this problem with his alcohol use."

He has complied with someone's insistence that he seek help "only because he does not want to lose those things that are most significant to him, and not because he believes he is an alcoholic."

Bars, pubs should be charged

MORE CHARGES should be laid against drinking establishments which serve customers who are already drunk, but it isn't as easy as it sounds, says a vice squad officer with the Hamilton-Wentworth Regional Police.

"The whole system of licensed establishments is to get you to drink as much as they can, and to spend as much as they can," Staff Sgt. Fred Pawluk told a correctional services workshop.

"Police are probably lax in this area ... but convictions are hard to get. In years gone by, if we sent bad reports on an establishment to the liquor board, they would take action. Now they wait for a conviction."

Staff Sgt. Pawluk was asked why customers were allowed to get drunk in bars, when it is against the law to serve someone already drunk. "Then they shove him out on the street when he doesn't have enough money left for a taxi to get him out of the way of the law," as a probation officer put it.

It isn't only a question of enough manpower to police the law, Staff Sgt. Pawluk said, but of proving the case. "The hotel can say the guy just wandered in and sat down. You have to prove they actually served him." A cynic in the audience added, "And 40 other guys will go to court and say he wasn't served."

The officer felt it was too late to raise the drinking age beyond 18. "The mistake was in lowering it. It sounds good to raise it again, but how can you enforce it? It's socially acceptable now, and to try and raise it would make a mockery of the law."

He also believed legalizing marijuana would compound the problem by making a better grade of cannabis available.

"Most of the kids are smoking the home-grown stuff, and it's like lettuce leaves — they may get a glow on for a few hours."

He was disturbed, however, by medical experts who say the drug is harmless. "I wish they'd go out with my officers and talk to some of the habitual users — not the kids with the odd roach on weekends. Their brains are like mashed potatoes after six months."

Employee assistance plans lack adequate follow up

MOST EMPLOYEE assistance programs still lack adequate follow-up procedures after an employee has gone through treatment, says an Addiction Research Foundation of Ontario regional consultant.

Ken Bennett of Hamilton, chairman of a workshop on alcohol and drugs at work, said most programs are also still only identifying employees in the late stages of their problem.

"It is just not realistic to believe a three or four week residential program, or a short series of out-patient counselling, or group sessions by themselves, will be adequate to effect lasting rehabilitation," Mr Bennett said. The program should include ongoing, perpetual maintenance, where company records can be used to determine if the employee is relapsing or slipping. He can then be confronted with the documentation of his unsatisfactory performance, as he is in the initial stages of the program.

Earlier detection is also possible with coordinated records that can monitor attendance, lateness, accidents, work quality, and health insurance claims, but often these records are scattered among various departments and offices in a company.

An EAP has three phases: work-up, therapy, and follow-up, and the treatment phase is probably the least important, he said.

It is the whole process of documenting poor work records, insisting that the employee do something about his problem or lose his job, and union-management cooperation in using this lever that is important.

"In many cases, the job may be the only practical means of intervention. Employee Assistance Programs are no panacea, but they offer the best approach developed to date," Mr Bennett said.

That was a recurring theme among speakers at the seven-day institute, sponsored annually by Addiction and Drug Concerns, Inc.

Dr Paul W. Humphries, senior medical consultant to the Ministry of Correctional Services, said they had the advantage of getting at the problem drinker earlier, while the person still has a job. They are showing a 65% to 80% rehabilitation rate, but this is based on job performance only. The employee may still be drinking, and still creating major problems at home, but he's showing up for work, sober and on time, and doing his job satisfactorily.

A. M. Blanchet, manager of employee relations at the University of Guelph, believed his institution is the first university in Canada with an official EAP. It has had an unofficial program for about two years, but it was made formal this summer.

Martin Shain, scientist with the evaluation studies section of ARF, reinforced Mr Bennett's "no panacea" comment in talking about results of a year-long ARF study of EAPs in Ontario.

Addict may go straight in winter

POOR QUALITY of most heroin on the streets has led to a new type of heroin user in the past decade — those who use it as a drug of choice, but don't get physically addicted, says a former researcher who lived among Niagara Falls, Ont. users for six months.

Kie Delgaty, now a probation and parole officer in London, Ont, said this type of user predominated among the approximately 100 users he knew in the border city in 1973.

They tend to have a history of chronic, multiple drug use starting in early adolesence, and were often "speed freaks".

He calls this group of occasional heroin users "runners". They often sold marijuana and hashish to high school students in order to get enough soft drugs for their own use, and to get money to buy heroin, but they were distinct from the small core of the elite who controlled heroin dealing in the community.

He recorded the one-month drug use of one runner as alcohol, marijuana or hashish daily; heroin, Seconal, Tuinal and Mandex several times a week; Methedrine, MDA, psilocybin, mescaline, Valium, Librium and PCP several times during the month, and opium, cocaine, and methadone a few times.

Yet in winter, many of these runners "go straight," take factory jobs, return to live with their families, and stop injecting drugs at least temporarily so they can pass physical exams to get jobs.

Mr Delgaty did have what he called "a couple of scary moments" in his encounters with the controlling dealers in the community. One dealer held a gun to his head, with the announcement that they were going for a ride and he was going to blow his head off. With some fast talking about his research project, Mr Delgaty was able to get that excursion called off. The dealer insisted he be interviewed for the study.

Some of the addicts saw addiction as a career, and had actively pursued it on the streets since their early teens.

Solo fights against traffickers are outdated

By John Shaughnessy

TORONTO — Law enforcement officials have not been quick enough in reacting to drug trafficking patterns around the world, says Michael G. Picini.

The breaking up of the French Connection did not have its desired effect because Mexico, "a monster lying dormant below our borders," was ready to take up the slack, and the South East Asian connection had already established its distribution channels in Europe.

Mr Picini, deputy associate director of the United States government's Office of Drug Abuse Policy, told the International Narcotic Enforcement Officers Association here that Amsterdam did not become a heroin distribution centre overnight.

"As far back as the early 1950s, we knew the Chinese were bringing opium into Amsterdam, but we ignored it because it was only the Chinese who were using it. By the time we became concerned, the traffickers had had their contacts and distribution channels in existence for years. All they had to do was switch from opium to heroin."

Today, though, law enforcement efforts are improving. "Internationally we are coming to recognize more and more that we have a veritable opponent, and that no single country can do the job alone. The US approach has changed from going into a country and doing their police work for them, to giving them moral and financial support and helping train them to do the job themselves."

Mr Picini said the positive results of the multi-country approach can be seen in the efforts of countries that previously had been unconcerned about drug trafficking. "These countries started late, but they have started and they are devoting more and more effort and resources to combating the problem."

The international approach also is having a greater impact and a more lasting effect on reducing the supply of drugs in source countries. International efforts in both law enforcement and in solving economic problems of the source countries are slowly improving the situation.

But Mr Picini emphasized that international trafficking in heroin and other drugs is still a formidable problem. "Law enforcement agencies must keep constant pressure on international trafficking. Otherwise people will give up. They'll say our laws are unenforceable and we'll simply have to live with the problem."

'Prohibitionist fervor has contributed to pandemic of abuse'

Government clinics should control opiate market

SEATTLE — A prohibitionist approach to non-medical drug use can do more harm than good, says a California psychiatrist.

The practice of condemning all such drug use as invariably destructive apparently has the objective of discouragement, but "our prohibitionistic fervor" has served to raise the level of interest in drugs and thus has contributed to our current pandemic of abuse.

According to John Kramer, associate professor, psychiatry and pharmacology, University of California at Irvine, it can be convincingly argued that the heroin problem, which mushroomed in the United States in the late 1940s, still exists because of, and not in spite of, the legal controls that were instituted between 1915 and 1920.

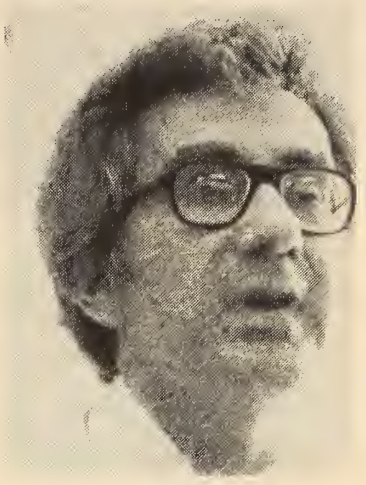
"By criminalizing addiction and even shutting off the option of medical maintenance we steadily reduced the prevalence of addiction for about 25 years. But our actions also helped to create a black market and to develop a hidden drug culture where drugs and technology were rapidly communicated through informal channels. For example, the intravenous technique was developed and dispersed in the 1930s; prior to that, oral and subcutaneous techniques were most widely practised."

Dr Kramer told a meeting here on Policy Alternatives in the Control of Alcohol Abuse, Drug Abuse, and Smoking that he would like to see the government gradually but steadily take control of the opiate market.

"My tendency would be to start with methdone maintenance and possibly expand into the area of heroin clinics. With this approach some people might have to be sacrificed — we might have to accept the idea that some people will be addicts for life.

"But this doesn't mean we must force everybody to become an addict. I don't want to make opiates and heroin available to those not already addicted, but we must at least give the existing addict the option of being the government's addict."

In the short term, this approach would likely serve to increase addiction, and for this reason Dr Kramer admits it would be a very difficult one to accept. Nonetheless, he believes control over the opiate problem will ultimately be attainable only through that means. "Even then we won't control it completely, but we can substantially decrease it," he said.



John Kramer

Dealing with drug control laws in general, Dr Kramer said many problems may have arisen from gross errors in estimating the costs and benefits. "We have perhaps over-evaluated the physical, psychological, and social dangers of drug use, while under-evaluating the costs which flow from legal controls."

In his view, controls will be useful in substantially diminishing overall use because most users or potential users are not sufficiently dedicated to their drug to flaunt the rules. But increasing the intensity of the controls, while it may further decrease the incidence of use, brings into the fold fewer and fewer people. Each sequential increment in control is less and less effective than the one which preceded it.

"As controls become more pervasive, the incidence of drug use diminishes and the benefits are obvious. Morbidity and mortality secondary to drug use are reduced; medical costs of treating those disabled are reduced; personal and family problems secondary to drug use are reduced. Overall productivity is increased because fewer people are disabled, and there is a rise in popular morale as the society's citizens denote these favorable changes.

"Concurrently, however, new problems are created or old ones become worse," said Dr Kramer. "Corruption and smuggling become more intense; the cost the dedicated user must pay goes up so much that his continuing drug use becomes a serious economic burden to himself, his family, and ultimately to the public. In addition, enforcement and punishment arises throughout. Such is the nature of non-medical drug use that there is not a drug for which some individuals won't accept great risks or impoverishment."

While non-medical drug use inevitably exacts a toll from individuals and society, any "catastrophe" can be avoided with relatively temperate controls, said Dr Kramer. Such controls would place restrictions on distribution which would make it relatively hard to become a user while permitting the determined devotee sufficient leeway to continue if he would not or could not desist.

"Society has an obligation to protect its members from the degradations of others. Perhaps too, it has an obligation to warn them and reduce the likelihood that they accidentally do injury to themselves. Punishing them when they either intentionally or accidentally disregard the warnings is not only costly and unfair but it has not proven to be an effective preventative of such behavior in others."

Social factors are ultimately far more important than control laws in affecting the prevalence of drug use, according to Dr Kramer.

Scale assesses drug risks / benefits

TORONTO — Conflicting and paradoxical reports on the advantages and disadvantages of drugs have promoted an Ottawa investigator to develop a model for assessing their risk-benefit ratio.

The model, called a "social profile", can be used for any drug, and evaluates its potential on the basis of benefits and beneficial attributes; risks to individual health and public health; risks to public safety; risks to dominant social order and traditional culture; and dependence liabilities of the substance.

Ian Henderson, associate professor of pharmacology and surgery at the University of Ottawa, and a policy advisor on drugs for the Non-Medical Use of Drugs Directorate of the federal department of health and welfare, told the International Narcotic Enforcement Officers Association here that almost all drugs have benefits and hazards.

His "profile", he believes, can assist individuals and governments in reaching unbiased and intelligent decisions concerning the role they wish a drug to play in their individual lives or in society as a whole.

Dr Henderson considers eight factors in evaluating the benefits of a drug. These include whether it is curative of illness; palliates symptoms; is effective in a severe or trivial illness; is unique as a therapeutic substance; the predicability of the desired response; the therapeutic index (advantages versus toxicity); whether it has a low incidence of adverse reactions; and whether there are any recreational or non-medical benefits.

Under risks to individual and public health, Dr Henderson considers the drug's impairment of "learning to cope" abilities; its dampening of healthy emotional response; brain damage; other organic damage; associated malnutrition; associated accident rate; the drug's "lethality" in an overdose situation; and the health risks when the drug is used recreationally.

Risks to public safety include induced deviant (potentially destructive) behavior; induced aggressive behavior including sexual aggression; judgmental deterioration; loss of psychomotor control; criminal behavior and violence; increased risk-taking behavior; loss of healthy anxiety, concern, and justifiable fears; and safety risks to individuals, communities, and the larger society when used recreationally.

With regard to the dominant social order and traditional culture, Dr Henderson assesses the drug's risk as it relates to induced low self-reliance; loss of creativeness; recruitment of non-users; degradation of ethical or moral values; socially unacceptable standards of behavior, dress, cleanliness etc; induced amotivational states; economic loss to the community; and rebellious inclinations when used non-medically.

The dependence liabilities are rated according to dependence potential after experimental use; dependence potential after regular use; severity of abstinence syndrome; potential for psychic dependence; drug seeking behavior; recidivism after periods of abstinence; reinforcing properties for man; and international abuse potential.

Dr Henderson said he rates all the factors on a scale of one to 10, and in this way a balanced picture emerges. "Very little is overlooked, and if the benefits outweigh the risks or vice versa appropriate decisions about the drug's role in our society can be made."

Overdosing is popular teen suicide gesture

MONTREAL — Suicide is the leading cause of death in Toronto and second in the rest of Canada in the 15- to 19-year-old age group.

And a suicidal gesture may precede the act as often as three times with the commonest method being drug overdose, the Canadian Paediatric Society was told at their annual meeting here.

Drs. Loys Ligate, an intern in paediatrics, and Martin G. Wolfish, chief of pediatrics at North York General Hospital, Willowdale, Ont, told the meeting: "Adolescents who merely gesture suicide are usually girls seeking attention by impulsively taking an overdose as a call for help.

"Attempted suicide is more common in boys who are moderately to severely depressed. Their attempt is well planned and is not communicated to others."

In a four-month period, 47 adolescents came into the North York General Hospital's emergency department after a suicidal act. Twenty-two were aged 12 to 19 years (17 girls, 5 boys). The drug most commonly used were Aspirin, Tylenol, Dalmane, and Valium. Frequently, alcohol was involved as well.

In a typical case, a 19-year-old boy took between 30 and 35 222's and alcohol. This was a third overdose and his girlfriend had gestured suicide one week previously. The chronic stresses involved were loss of a job following a motor vehicle accident, a debt of $300, alcohol abuse, and a parting with his girlfriend. His father, the history showed, was an alcoholic.

"In our study of these cases," Dr Ligate said, "we found adolescents who gesture suicide have poor family, social, and academic histories. They are mildly to severely depressed with a poor self-concept. Usually, there is a precipitating factor in addition to the chronic stresses."

DWIs pack DC courts

WASHINGTON — A concentrated police campaign to apprehend drunk drivers on Washington streets has been so successful the courts have had to adopt an emergency plan to deal with cases.

During the first six months of 1977, District of Columbia police arrested 2,613 drunk drivers. In all of 1974, only 900 drunk drivers were arrested.

A $530,000 grant has been made by the United States department of transport to give police special training, breath testers, and equipment to carry out the campaign.

The campaign has produced a huge court backlog. Those arrested for drunken driving can demand jury trials and such requests have risen from 375 a month in 1976, to more than 600 a month this year.

At the therapeutic communities meeting (left to right) Claude Orsel, Eva Tongue, Msgr William O'Brien, Peter Howlett, Peter Bourne, John Devlin, Mrs John Devlin.

TCs gain acceptance as effective drug treatment

Dorothy Trainor reports from the 2nd World Conference of Therapeutic Communities hosted by Portage Institute, Montreal

THE THERAPEUTIC community has come of age as an effective drug abuse treatment, says Robert DuPont, director of the United States National Institute on Drug Abuse (NIDA).

"The latest findings of the Drug Abuse Reporting Program's five-year follow-up studies, sponsored by NIDA and received just four weeks ago, once again bear out this fact," Dr DuPont told the meeting.

A keynote speaker, he abandoned his "carefully prepared text" to speak informally but issued his paper to the press. It said:

"Data on therapeutic communities, adjusted for age, ethnicity, and other background factors, has demonstrated that all groups of clients who participated in TC and other drug-free regimens during their treatment experience, regardless of other aspects of that treatment outcome, 1) had significantly fewer returns to treatment, and 2) remained in those subsequent treatments for significantly shorter periods of time than clients from other regimens in the three years following their TC experience."

Further, the number of days in TC treatment shows a high correlation with reduced levels of opiate and other drug use, reduced criminality, fewer returns to treatment, and increased employment in the first year following treatment.

"These findings support cost-effectiveness arguments, while another important aspect of the TC in the United States is its general acceptance by the criminal justice system as an appropriate placement for involuntary referrals."

Dr DuPont, who himself spent two years working in TCs and has visited them across the country, found that all drug abuse treatment owes much to the TC movement.

"Although no longer predominantly TC-based, drug-free treatment still takes much of its energy from the therapeutic community movement. A cadre of experts has grown out of the TC movement in the US — often graduates of the TC experience themselves. These experts have made significant contributions to every area of the drug abuse field.

"The therapeutic community has come of age. There is no longer any need to feel threatened by alternative approaches to drug abuse treatment nor to resist modifications in the traditional TC model that will serve a wider variety of clients.

"A recent NIDA-sponsored cost benefit analysis estimated that for every dollar spent on TC treatment, as much as $2.25 is saved in social costs related to drug abuse.

"There is no question the future of the therapeutic community in the United States is bright. It is a vital movement and there are important areas toward which to channel its energies."

Robert DuPont

BC, Ontario considering Quebec's Portage model

BRITISH COLUMBIA and Ontario are both "seriously interested" in developing therapeutic communities modelled on the Portage Program for Drug Dependencies in Quebec, says Portage executive director, John Devlin.

He told a press conference that representatives from both provinces had visited Portage in the last past several months. "The discussions concerned the development of therapeutic communities in the two provinces à la Portage." In each case, he said further meetings were scheduled.

"In terms of Portage's priorities, it would be more feasible to replicate the model in Ontario first — mainly for logistical reasons but also because BC still has to straighten out its intentions with respect to compulsory treatment of addicts."

Asked about funding, he said: "Obviously both provincial governments would have to fund the TCs, but just what agencies will be responsible still remains to be worked out. Here in Quebec, we have a foot in two fields — health and corrections — and we are proposing that there be cost-sharing arrangements with the ministries of justice and health, and the federal government, since the latter has jurisdiction over parolees."

As to structural changes in what is now a bilingual program, Mr Devlin stated he would anticipate fewer problems in establishing the program in other provinces.

"The first step would be to take a core group from Toronto or wherever and train them at our treatment centre at Lac Echo and then transfer the core group — as a family — back to their native area."

To date, only three drug abuse treatment therapeutic communities exist in Canada, although there are up to 300 TCs in the drug abuse field in the United States.

'Condemned to leisure'

Jobless youth add new dimension to world's drug abuse problems

THE FACT young people now are often condemned to leisure and ill-prepared for it, constitutes a new and threatening dimension in the drug abuse field, according to Peter Bourne, special advisor on health matters to United States President Jimmy Carter.

"Massive unemployment among the youth of the world has meant that drug abuse and addiction has become less and less an American problem," said Dr Bourne, special adviser on health to United States President Jimmy Carter.

"The phenomenon of unemployment exists to a greater degree in some European areas than in the US — with its attendant drug problems and crime. The European Economic Community also has an involvement. Since border barriers have been removed, drugs are moved around the European continent with ease," he said.

Heroin use has shown "a tremendous increase" in Europe, he said, and it is a growing problem in Israel where heroin comes from Asia but is transshipped from Amsterdam.

Heroin-related deaths in the US, however, are down as a result of international intervention in opium poppy cultivation, he said.

"As a result, we have seen a signficant decline in the purity of heroin in the US in the past six months. The purity is down to its lowest level in five years."

On the subject of decriminalization of amounts of less than one ounce of marijuana, he spoke only briefly.

"The President's message to Congress which contained the reference was more symbolic than anything else. It was a symbol of our attempt to focus on the major problems rather than being distracted by things which are not as consequential in a relative sense."

There should not be laws to control drugs, Dr Bourne said, that are potentially more dangerous than the drugs themselves.

Funding favors methadone

UNITED STATES Government funding policies in the drug abuse field are heavily weighted in favor of methadone treatment, Frank Natale, program director of Phoenix House Foundation, New York, told the conference.

"There was no real national policy until 1971, when a policy emerged as a reflection of concern for returning addicted Viet Nam veterans and government's inability to stem the rising tide of street crime," he said.

When a policy developed, he claimed, what it was really about was to preserve existing treatment forms and it favoured methadone maintenance.

"The influencing factors were the low cost of methadone, the speed with which methadone clinics can be started, and a main concern with quantity of care — not quality of care.

"This federal policy did not put TCs out of business. There were funds for us, but opportunities for growth were very limited."

Federal policies, he said, can both create and limit drug abuse, and creation comes into the picture as a side effect of those policies. Such policies do not set out to addict citizens, but can produce a higher incidence of drug abuse.

"Government must admit that, while methadone maintenance patients show reduced levels of criminal activity, that reduction is in no way comparable to the reduced levels achieved by the TCs — although this is not a good argument for treatment facilities. Controlling drug abuse is the job of law enforcement agencies. Cardiac units are not judged by the prevalence of heart disease.

"Government needs to know how much 'cure' it is buying for the treatment dollar. They need to know that if methadone maintenance involves a lifetime of treatment, it is many times more expensive than the comparatively short-term but higher cost of the TC."

TCs flourish under benign neglect

THERAPEUTIC COMMUNITIES in the drug abuse field have grown and flourished best in periods of benign neglect, according to Vincent Marino, executive director of The Habititat, Inc., Hawaii.

"We were able to begin our programs, run them, and use whatever tools we felt necessary for the good of our people. Our past records are ample proof that given the freedom to create, we were able to function successfully. We achieved, we salvaged lives — including our own — despite the lack of degrees and certificates," he said.

"I do not doubt the sincerity, honesty, or dedication of the professionals. However, the fact remains that within the TC setting, their methods and conventions don't work for our people. Our methods do. Yet by regulation, by state and federal governments, we are now being called upon to accept their unworkable methods and conventions. . . . ."

The remarks concerned the need for self-reliance within the TC milieu and self-sufficiency with respect to finances. As Mr Marino stated: "Outside monitoring agencies are breathing hot and heavy down our backs, creating pressures and hassles with an ever-increasing pyramid of regulations, mainly promulgated by professionals within such agencies.

Pot is 'trendy' but dangerous

TORONTO — Cannabis use today is part of a "trendy" experiential movement that concerns pleasurable altered states of consciousness.

And the risk in this trend, according to Ian Henderson, a policy advisor on drugs for the federal health department, Non-Medical Use of Drugs Directorate is that there is a temptation to ignore a subtle seductive propensity for development of the drug-induced state as a preferred state of consciousness.

"The danger then exists that the preferred state is equated with normality, and the non-altered state is regarded as depressed, apathetic, and 'dullsville'," he said.

"Positive and negative reinforcement induced by the drug will then tend to lead to habituation and an increased pattern of utilization. Dependence is then only a stone's throw away."

This danger in marijuana use was only one of several outlined by Dr Henderson during a marijuana panel at the meeting here of the International Narcotic Enforcement Officers Association.

Dr Henderson said the current answers about the effects of cannabis demonstrate exceptions, contradictions, and even paradoxes, but in general the health concerns include the acute intoxication picture, problems of chronic use, and the therapeutic potential which cannabis may have in a number of disease states.

The acute effects, which most of the time are pleasant, may induce a panic reaction, he said. There is, however, decreased psychomotor control, a degree of incoordination, and increased color-naming errors. The combination of alcohol and cannabis is particularly hazardous in that the human brain can compensate to a limited extent for alcohol and, with some practise, for cannabis but for the combination the effects are quite uncontrollable.

Dr Henderson said cannabis studies also suggest the transfer of items resident in the short-term memory are not transferred to the long-term memory stores, from which they are retrieved at a later time. "There is a failure to recall correct information, and an increase in inaccurate recall."

With regard to work motivation, Dr Henderson questions the conclusion in the Jamaican ganja study that the drug is an "energizer." He said energizing aspects of ganja seen in that study were likely associated with a withdrawal reaction.

"On withdrawal of the drug there is irritability, with a disinclination to concentrate on any task. When the person in withdrawal is provided with his drug, there is restitution of tranquillity and in his euphoric state he will once again turn his attention to a work task."

Further, said Dr Henderson, the quality of work performed under cannabis is less efficient than non-drug associated work. In an Egyptian study, laborers in the upper part of the country showed little or no diminution in work capacity, but in lower Egypt the ability of cannabis smokers to carry out skillful tasks and intellectual functions was measurably diminished.

The phenomenon of state dependent learning is also of concern to Dr Henderson. He said data stored in the brain under the effect of a drug (and thus a modified brain circuitry) is best recalled under the same or similar circumstances.

"The significance of this relates mainly to students who have to recall and remember large amounts of material on cue. That which has been imprinted under even small amounts of cannabis is either not recalled, or is recalled incorrectly because it has been improperly stored or coded."

With specific regard to the lung, Dr Henderson said there is no reason to believe cannabis is safer than tobacco smoke. In fact, there is evidence that it is more toxic. He said the book, *Ganja in Jamaica* gives the impression there is no evidence cannabis is harmful in terms of the physiology of the lung but "the persons studied in Jamaica were anything but mutually exclusive in that non-smokers did not necessarily not smoke tobacco, but merely did not smoke cannabis with tobacco.

"The question of cannabis and chromosomal aberrations remains unanswered, and studies of cannabis and reproduction with special reference to possible chromosomal changes and birth defects engendered by cannabis chemicals, are still fragmentary and poor."

Ian Henderson

The effects of small doses of cannabis on a healthy cardiovascular system are probably not important as a health hazard, according to Dr Henderson. But he said it may be more hazardous in middle and old age because "for older persons with some degree of coronary artery narrowing and insufficiency of blood flow to the cardiac muscle, any drug which acts as a cardiac stimulant can be dangerous from the viewpoint of cardiac irregularities, with a disproportion between oxygen needs and oxygen availability through narrowed vessels."

Recent work has confirmed reports that chronic intensive use of cannabis depresses plasma testosterone levels, and a few clinical reports suggest a number of persistent psychological and intellectual problems are very long lasting — if not permanent — after heavy cannabis use.

"It is probable that high doses of cannabis do change the biochemistry of brain eells to the extent that structural ehanges eventually occur," said Dr Henderson.

Another attribute of cannabis, which he feels has special importance for Canadians, is that it produces an altered physiological state where the body begins to equilibrate with the temperature of the air around it. Serious cooling could easily take place, and this results in muscle stiffness, disinclination to exercise, inability to shiver, and finally drowsiness and coma.

"One can imagine dangerous situations in Canada during winter, if a snowmobile breaks down or an aircraft is downed in sub-zero arctic temperatures," he said. "Young people who are determined to use cannabis to enhance their enjoyment of outside winter activities should be warned of this effect."

BDD: It's fussy very quickly

(from page 1)

ing they may have a personal drug file can determine whether such a file exists merely by asking the Bureau of Dangerous Drugs in Ottawa.

Once their identity is verified, they will be told whether the file exists. Previously, no one could even get confirmation that such a file existed.

After that, what the bureau will allow individuals to see, if anything, becomes very fussy, very quickly. And here is where the potential for a clash with the human rights legislation exists.

Drug crimes

A B Morrison, assistant deputy minister in charge of the Health Protection Branch, told **The Journal** that where information contained in a file is public information — such as drug crime conviction information obtained from court records — this would be released to an individual on request.

But if the source of the information is considered confidential, then this type of information would not be released, based on a fear of implicating others, he said.

The best example of this category would be information collected by police, using informants or undercover agents, on drug use.

Another health department spokesman noted that if a doctor had provided information to the health department on an individual and his drug use habits, then the doctor would obviously not want this known to his patient.

Thus, in effect, the health department's current policy is that they will confirm that a personal file exists, but will not let the individual see its contents.

Dr Morrison also noted there are three types of drug files: lists of professional drug users, mostly doctors who have become hooked on drugs they prescribe; lists of individuals who inadvertently become hooked on drugs they have been taking for medical reasons, for example, cancer patients who have become addicted to narcotic painkillers; and, by far the largest list, users of illicit drugs.

The last category includes not only more than 163,000 cannabis users, but also the names of more than 15,000 users of narcotics such as heroin, and more than 21,000 hallucinogenic drug users. Police, doctors, drug treatment centres, pharmacists, and court records are used to obtain information for the files.

Dr Morrison said if the department is told by the police that an individual is a drug user, whether the drug is cannabis or heroin, he/she is automatically listed as one by the Bureau of Dangerous Drugs. No checks of the police information are made.

Court records of convictions in recent years are eliminated, as of a 1975 policy, in the health departments files if the individual gets a pardon and if the justice department passes that information along to the health department.

Human rights

Dr Morrison said records are also eliminated if there is no activity on the file for 10 years.

Gordon Fairweather, the human rights commissioner, told **The Journal** that individuals wanting to know what is in their files at the health department should first apply to the department for access.

If they don't get the access they want — that is actually see the file and have a chance to correct misinformation — then they should call the Human Rights Commission for further action.

He cautioned that the privacy provisions of the Act, which cover access to private government records, won't be proclaimed into law until early next year and that the Privacy Commissioner Inger Hansen (former ombudsperson to federal prison inmates) has only just started work.

At the same time, Mr Fairweather said he has no doubts the privacy provisions will be useful forcing the health department to open up its files to affected individuals, especially since the drug user files are supposed to be used for health and treatment purposes.

Mr Fairweather said he didn't think the government could hide behind "national security" or even the "criminal activities" exemptions under the Act, especially when it comes to cannabis users.

Destructive

"I don't think that a user of heroin ... or cannabis for that matter ... is endangering national security, sad and destructive as the drug use might be to the individual," he suggested.

"We will be quite legalistic," he promised, "in our interpretation of what should and should not be made available to individuals.

"Our goal is openness and the government of Canada by putting us here will inevitably lead to a test of just how open the government will want to be," he said of the Human Rights Commission, adding that if the commission doesn't believe it has enough teeth to get access to the information it feels should be available, then it will go back to parliament for more powers.

Dr Morrison stressed the information in the drug files is not supposed to be passed on to police, though it is routinely given to doctors on request to help in determining the proper treatment for drug users.

He also noted Canada has a responsibility under the United Nations Single Convention on Narcotic Drugs to gather statistics on drug users and drug use in Canada.

Viet vet pardoned

RICHMOND, VA — A decorated United States Marine Corps veteran of Vietnam who was sentenced originally to 120 years in prison for drug offences has been pardoned by Virginia Governor Mills Goodwin.

David Etheridge was accused in 1972 of selling an undercover policeman less than half an ounce of marijuana, less than an eighth of an ounce of phenobarbital, and 49 LSD tablets. The jury recommended three consecutive 40 year sentences, but the trial judge made them concurrent.

It is the second time this year draconian sentences in Virginia for drug offences have been upset. A man sentenced to 40 years in 1974 for possession of a small amount of marijuana was freed by a federal court on grounds the term was cruel and unusual (**The Journal**, June).

Thebaine

(from page 1)

Board to make certain there will be available throughout the world thebaine for the production of non-codeine products," he said.

The United States decided to prohibit commercial cultivation of *Papaver bracteatum* for basically political reasons, according to Mr Miller. "For years we have been leaders all over the world in opposing the production of opium poppies, but most people can't make the distinction between opium poppies and *bracteatum* (scarlet) poppies. If we allowed the cultivation of *bracteatum* in the United States we would not be able to exert pressure on other countries to stop or reduce their production of opium poppies. They would say we were easing the over supply and they would cut back only when we went out of production."

Asked about the significance of Mr Miller's remarks, Dr Smith told **The Journal** that a reversal of the US decision is not likely in the near future. The thebaine requirements for codeine production are being met now, and the time when non-codeine products requiring thebaine will be commercially produced is still a long way off. Much research has still to be done, and any new drugs must go through the approval process of the US Food and Drug Administration before production requirements would mean a substantial increase in the demand for thebaine.

Dr Smith said that as a sovereign nation, the US can decide to produce *Papaver bracteatum* at any time, but he hopes and expects it would consult with the international community before taking such a step.

"If and when the supply of thebaine ever becomes inadequate, the need could theoretically be met by a country other than the United States, but the US still could decide to produce its own."

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Letters to the Editor

NORML objections

Harvey McConnell's article "Cannabis Dilemma Plagues DuPont" and Comment "Has the Public Been Misled?" (**The Journal**, August) are both unduly alarmist regarding the effects of the move towards marijuana decriminalization.

Surveys of marijuana use in the United States show that usage increased much more dramatically in the late 1960s and early 1970s, when the government branded it a "killer weed", than it has in the past few years since the Shafer Commission first called for decriminalization.

Moreover, the enormous human, fiscal, and social costs of the marijuana laws are being reduced by decriminalization.

Dr Robert DuPont's observation that "the move toward decriminalization is . . . interpreted widely by the public as a move towards permissiveness with respect to marijuana," is strange. A policy of decriminalization is inherently permissive, for it is not based on the premise that marijuana use is harmless or that it should be encouraged, but rather that such use should fall within the ambit of personal choice permitted in a free society. It is a policy which permits personal choice, rather than prohibits it.

The public has not been misled over decriminalization. Rather, the government and its top drug officials are slowly beginning to tell the truth about marijuana after more than half of a century of deceit and dishonesty aimed at generating an irrational fear of marijuana to bolster a totally unwarranted and repressive prohibition of its use. It was prohibition which was viciously misleading; decriminalization is a step towards honesty.

Gordon S. Brownell
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'Half-truths make news'

I have read the article on page five of **The Journal**, August, entitled "FDA committee behind the times: Ungerleider." As usual, Dr Ungerleider, who is a specialist in overstatement (the third paragraph of the article is typical), is working hard for what some people believe to be his ultimate goal — legalization of marijuana.

Ungerleider, by use of shocking statements, half-truths, and overstatements gets the news coverage, but in the interest of scientific research, I have yet to discover anything vital or substantial to build his case for either decriminalizing or legalizing marijuana.

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Inside Science

Alcohol and CNS drugs

By J. M. Khanna*

It is well known, from both clinical and experimental observations, that the effects of alcohol and other central nervous system depressants (such as barbiturates, tranquillizers, antihistamines, etc.) are enhanced, when they are given in combination. Such studies on acute interactions of alcohol with barbiturates and tranquillizers have been undertaken by many investigators.

Unfortunately, there is still controversy as to whether these drug combinations produce *potentiation* (i.e., a combined response greater than the sum of the separate effects of the drugs) or *additive synergism* (arithmetical summation of effects).

The reason for this controversy is that in most of these studies, only one or two dose levels of each drug were used, rather than a range sufficient to provide dose-response curves.

Secondly, no consideration was given in most cases to the time of peak effects of each drug.

Thirdly, the responses examined were either of an all-or-none type, e.g. death, or of a crude and imprecisely quantifiable type, e.g. sleeping time.

Such difficulties can give rise to serious misinterpretation of the results. For example, if one or both of the individual doses are below or near the threshold of the response being studied, or even if they are on the lower part of the dose-response curve, it is expected that the combination will have a greater effect than the sum of the individual effects.

A different kind of combination effect, which is also very common between these central nervous system depressants and alcohol, is that seen when chronic treatment with one of the compounds is followed by administration of the other compound. It is frequently stated that alcoholics are unusually resistant to the actions of various sedatives and hypnotics and to the induction of general anesthesia. Similarly, barbiturate addicts show only moderate signs of intoxication after very large doses of alcohol when it is substituted for barbiturates. This phenomenon is referred to as cross-tolerance.

The mechanism of this enhancement and cross-tolerance, however, is still not certain. Until about a few years ago, it was generally believed that acute interaction and cross-tolerance between alcohol and other sedative-hypnotic drugs is due to the interaction of these drugs at the central nervous system. In other words, a greater impairment due to the combination of alcohol and other depressant drugs occurs simply because all these drugs act independently on the same area(s) of the brain. In fact, it is generally believed that, in terms of their broad effects on the central nervous system, it may be difficult to say anything that is unique about alcohol that you cannot also say about the general anesthetics, the barbiturates, and other sedative-hypnotic drugs.

What is different between one of these depressant drugs and another? Actually, very little. The differences are mainly in (i) the concentration that you need of a given drug to produce an effect, (ii) the shape of the dose-response curve and (iii) differences in the relative effect on one tissue compared to another. As an example, the more marked initial stimulation observed with ethanol compared to barbiturates is not due to any unique or different effects of ethanol. It is due simply to the way human beings normally drink alcohol. In other words, the shape of the dose-response curve, and the circumstances under which most people drink, make is easy to spend a fair amount of time in the minor degrees of intoxication, whereas with other depressant drugs you are more likely to pass very rapidly through the minor stages of intoxication into frank stupor, sleep, or coma.

That tolerance to one of these depressant drugs will produce tolerance to another unrelated depressant, or enhanced response on simultaneous administration, is therefore understandable. Furthermore, the abstinence syndrome observed with barbiturates and other central nervous system depressants, is similar to that seen after ethanol, and a high degree of crossdependence among CNS depressants and alcohol has been observed.

In general, any sedative-hypnotic can be substituted effectively to suppress the symptoms of alcohol withdrawal and alcohol can very substantially, although not completely, suppress the symptoms of barbiturate withdrawal. In fact, this phenomenon is the basis for the substitution of minor tranquillizers in the treatment of alcohol dependence.

Backgrounder

Malaysian teenagers chasing the dragon

THE SMARTLY-DRESSED 16-year-old Malaysian school boy, Hooi Heng, looked what his teachers believed he was — the respectable son of a prosperous Chinese businessman.

Then one day a teacher overheard Hooi in idle conversation mention "chasing the dragon." It was just enough to suggest to the teacher that the school might have a serious drug abuse problem on its hands.

After consulting the principal and guidance counsellor, the teacher ensured a discreet watch was kept to gain proof. And although nothing concrete emerged, within two weeks the principal decided the size of the problem warranted his submitting the school's prized and honorable reputation to scrutiny by outsiders.

By his estimation, about 100 of the school's 1,000 pupils were involved in smoking heroin in spiked cigarettes. The reference to "chasing the dragon" was to a craze that swept through Malaysian schools last year, smoking heroin alone.

Education head office "experts" were called in. They asked the principal to call together the pupils he believed had a drug problem. About 80 were assembled.

The "experts" had decided the best way of tackling the situation was to seek the pupil's confidence and get at least some to admit they had a "problem" that needed solving.

But the experts also had a problem; how to get the pupils to say something about what was happening without individually charging them, in the absence of hard evidence, and to avoid sending the suspected heroin smoking still further underground.

How secret is secret?

The group was first told that anything they volunteered would be treated "in confidence". A question from a pupil soon destroyed that idea. How confidential is "confidential" he wanted to know.

But it opened up further questions that showed some boys believed they did have a drug abuse problem. "Is the treatment painful?" "Can we get over it just with will power?"

Obviously, some pupils had heard of the pain and suffering of the "cold turkey" method of detoxification.

The upshot was that pupils who felt they had a drug problem were invited to write their names on a sheet of paper. Other pupils could write anything they chose. This way everyone was seen to write something thus avoiding accusations of informing on colleagues. Some names came up, confidential meetings arranged, and eventually the core of the problem sorted out.

As with most Malaysian schools, pupils were mainly of Chinese or Malay origin.

Care had to be taken not to enflame traditional antagonisms, although this factor enabled authorities discreetly to play off one group against the other in terms of getting pupils to volunteer information. According to a senior Malaysian educationalist, who related this story, the pupils of this school were lucky. They had a principal prepared to take a risk to salvage something for them.

Although government policy is to regard drug addiction as a social disease, many schools duck facing the problem, either sweeping cases further from help by confronting pupils with traditional authoritarian solutions or pretending there is no problem and ignoring those obviously needing help.

School pride is sometimes a factor here. Also, lack of proximity between teachers and their pupils creates difficulties for authorities attempting to assess the extent of the problem.

As one person described it: if 150,000 Malaysians are heroin addicts, it probably doesn't matter much to New Zealanders. Similarly, if 1,000 Australian school children are addicted, little sleep is lost in New Zealand. But if your neighbor were an addict then it would assume the scale of a national calamity.

"We are trying to find a way to tell Malaysians that if they see or have a drug problem, it matters and not to sweep it under the carpet because of their pride."

Cigarettes are heroin-laced

Authorities in Malaysia concerned with the drug problem are now of one view — that the period of complacency, scepticism, disbelief and keeping drug addiction under the carpet, should be long gone.

One factor that brought authorities together was the findings of a survey by the University of Malaysia. In particular, the survey indicated cigarette smoking was a significant platform from which pupils, about 12% or more than 16,000 surveyed, graduated to using heroin, mainly by smoking it in spiked cigarettes. Another feature was that for every pupil who admitted using a potentially addiction-forming drug, another five said they had not used them but were interested in doing so.

The survey showed that young people began taking drugs like cigarettes, cannabis, alcohol, and heroin mainly for two reasons — the drug was available and they were fascinated or curious to try it. The pressure of peers to "give it a go" and be a member of the "in" group was also apparent.

A lesser number began taking drugs for the "excitement", to alleviate boredom and run away from other problems, one significant problem being a feeling of not being able to match up to family pressures to do well at school. Based partly on the survey results, Malaysia has developed its own integrated drug education program which began on January 1, 1977.

The program replaces the former methods on the grounds they have been counter-productive. In particular, the survey revealed that United States films on drugs shown by Malaysian schools had backfired. Instead of putting pupils off, scenes of young Americans injecting themselves had made many curious to try it for themselves.

Also, using the findings of the survey that about 80% of pupils are not interested in taking drugs, education authorities reasoned there is little point in confronting them with information that may make them curious.

Sense of values is new focus

Instead, a drug education program has been devised with hardly a mention of such terms as "drug" or "drug taking". Based on a technique known as value substitution, terms such as "good" and "bad", "right" and "wrong" are included in an open-ended way so pupils can project back to their own sense of standards, regardless of whether they are a mixed group of Chinese, Malay, or Indian.

Teachers are required to be more highly trained and sensitive to classroom discussion situations to get the most positive result. Teachers, however, are being fully acquainted with information about drugs, even though they have been specifically directed not to show drug taking methods and equipment.

Part of the aim and hope is that when the topic comes up, as it did in the idle comment by Hooi, a teacher can latch on to its significance, take further action if necessary and, especially, know not to pass a value judgment (by reading the riot act) or alarm pupils who may have a problem requiring professional attention.

— potentiators or additives ?

Because of these well known facts, it was therefore believed that interaction between ethanol and other depressant drugs occurs exclusively at the central nervous system level.

Furthermore, until a few years ago, it was generally believed alcohol is oxidized primarily, and perhaps solely, by the liver alcohol dehydrogenase, an enzyme present in solution within the liver cells, whereas other drugs such as barbiturates and minor tranquillizers are metabolized by an enzyme system (mixed function oxygenase) located in certain cellular structures called microsomes. Because of the different requirements of these two enzyme systems, interaction among the drugs metabolized by them would be less likely.

However, renewed interest in this topic started when Dr Charles Lieber observed that microsomes can also oxidize ethanol *in vitro*, possibly by the same enzyme system as that involved in the metabolism of barbiturates and many other drugs. Because of the important implications of a common pathway for ethanol and drugs, this system, designated MEOS (microsomal ethanol oxidizing system), aroused a great deal of interest. It might provide an explanation, at least in part, for the following:

(1) ethanol metabolism *in vivo;*
(2) the resistance of alcoholics to hypnotics and anesthetics;
(3) the lesser degree of intoxication with alcohol in barbiturate addicts;
(4) metabolic tolerance to alcohol in alcoholics;
(5) enhancement of effects due to simultaneous intake of ethanol and drugs.

Although the bulk of the evidence failed to support the idea of a significant role of MEOS *in vivo* in alcohol metabolism, either after a single dose or after chronic administration of ethanol (i.e., metabolic tolerance to alcohol), it provided many interesting observations on alcohol-drug interaction and alcohol-drug cross-tolerance. An increase in blood clearance of many drugs such as meprobamate, chlordiazepoxide, diazepam (minor tranquillizers), dilantin (an antiepileptic drug), and tolbutamide (an antidiabetic drug) in human alcoholics has been demonstrated.

Thus, in addition to CNS adaptation, the decreased effects of these drugs in the chronic alcoholic is due to faster metabolism of these drugs. On the other hand, chronic treatment with drugs does not increase ethanol metabolism. Therefore, tolerance to alcohol in barbiturate addicts is due to tolerance at the CNS level and not due to faster metabolism of alcohol. Similarly, numerous investigators have shown that alcohol inhibits metabolism of drugs such as barbiturates, whereas drugs do not inhibit alcohol metabolism.

It appears therefore, that interaction of alcohol and drugs is a one-sided phenomenon, i.e., alcohol inhibits drug metabolism and chronic alcoholics display increased drug metabolism, whereas drugs do not inhibit alcohol metabolism and drug addicts do not remove alcohol faster than naive individuals.

The precise mechanism for inhibition and enhancement of drug metabolism by alcohol, however, needs further exploration. There is also need to know whether such effects of alcohol are limited to only a few drugs or they are generalized to a wide variety of drugs.

*** Dr Khanna is a scientist in biological studies, Addiction Research Foundation of Ontario.**

Dutch DJ helps set street marijuana prices

Drug taboos are tackled on his weekly radio show

By Larry Scanlan

AMSTERDAM — Koos Zwart is a DJ with a difference. His denim jeans and jacket, inscribed T-shirt, dark glasses, and trooper's hat are typical enough. But the content of his radio program is not: each Saturday up to one million Dutch listen as he broadcasts a 35 second 'market report' on cannabis prices in Holland.

The five minute editorial which follows is usually aimed at educating people about drugs, but often as not the Dutch police get lambasted.

Interviewed recently in Amsterdam, Mr Zwart told **The Journal** his broadcasts are not popular with either the police or the government but that owing to the peculiarities of Dutch radio licencing there is little they can do about it.

He explained that each interest group in Holland (political or religious, etc) which can claim 400,000 subscribers is eligible for its own radio programming, funded by the government. Once a licence is granted, it is practically irrevocable.

Seven years ago the Dutch Socialist Broadcasting Corporation invited Koos Zwart to do some programs on drug education and although it's hardly been smooth sailing since then, Mr Zwart is still afloat.

Around two every Saturday afternoon, during a program on Dutch politics called "In de Rooie Haan" (In the Red Hand) Zwart lists nine cannabis varieties, their country of origin, and average street price, the result of some 50-60 weekly reports he receives from country-wide users. The "command" or editorial is informative but opinionated. For example, he says, "I educate people that 70% of heroin comes from Thailand (sic) and will only stop with a change of power in that country (sic). Holland, by the way, gives foreign aid to Thailand."

Why broadcast cannabis prices? Zwart puffs on his cigar and replies: "To advise people and protect them, that's all; if someone wants to pay 100 gilders (approximately $42) for a gram of hashish he can, but I advise he doesn't.

"At first, the program was a mere reflection of what was happening in the street, but now the prices I give are a kind of ruling." So he is in fact establishing prices? "Yes," he says, not bothering to hide his satisfaction.

Former editor of a Dutch music magazine which eventually folded when its readers persisted in sharing rather than buying copies, Zwart also produces a weekly, two-hour rock music selection, heard on the same network as his drug program.

The very idea of broadcasting drug prices has never ceased to anger some Dutch while delighting European features editors. More than 200 television crews, some from as far away as Australia, have interviewed Zwart in the past three years. Outspoken, articulate, and looking every bit the resident hippie, he is a journalist's delight.

There are few drug authorities in The Netherlands who can match Zwart's contacts on the street drug scene. The Foundation for Drug Information, which he established himself, now has 125 volunteers and regularly puts out warning bulletins when dangerous impurities appear in street drugs.

His radio editorials are not off-the-cuff remarks from a cannabis advocate, but researched and footnoted. His basement is an impressive library of drug research and literature.

But, using radio is only half of Zwart's campaign to smash the public taboo around drugs. He also has a three-hour slide show/lecture on drugs which he takes around to schools, parents, doctors, soldiers, and anyone else who will pay his 150 gilder fee. A high price he admits, "but we are not government funded." His talk covers the nature of drugs, how they work, and their risks.

"Drug information in this country was for 20 years done by the dealers," Zwart points out. "My only hope is that after hearing the presentation and someone meets a dealer who says 'this is good for you' he will know it is not. We're arming him with information." The shake-a-finger approach, warning that drugs are bad for you and will lead to prison, has been tried before and it doesn't work, he adds.

Despite the fee, and imposed restrictions ("no more than 60 people and we reserve the right to say what we like") the demand for Zwart's "road show" is considerable and they are now saving money for a second projector. In the last eight years they've done more then 800 lecture dates.

For six of those years, part of the demonstration was a brief case containing samples of all the drugs — including the opiates — discussed in the lecture. Although Zwart was clearly breaking the law by using the case (and thereby 'transporting' heroin) Dutch police turned a blind eye for years. However, they chose to arrest him 15 days before new drug laws were enacted last November making the educational use of opiates legal when a 150 gilder permit has been purchased. According to Zwart, the old drug law required an opium permit costing 5000 gilders, much beyond his DJ's salary.

Amsterdam marijuana boat — thick and wavy with pot plants

The result of Zwart's arrest was an April 1 court case (a government April fool's joke) during which he presented his three-hour slide show as evidence in his defence. He was fined 150 gilders.

The offending case, meanwhile, remains with the ministry of justice which informed Zwart — with classical Catch 22 logic — that the brief case will be returned when he shows his educational permit. That was applied for six months ago and not a word has been heard since.

The new Dutch drug laws, while introducing the somewhat elusive opiate permit, also ushered in stiffer penalties for heroin traders, tripling the old penalty of four years in prison. Users are liable to fines of from 10-25,000 gilders. But Zwart insists harsher penalties won't reduce heroin dealing or use: they merely triple the dealer's risk, thereby tripling the price.

Looking at the history of Amsterdam's heroin boom, Zwart comments that between 1956 and 1972 Dutch police ignored the heroin threat, focusing all their energies on wiping out cannabis use: "In 1956 the last dog who could sniff opiates died and he was replaced by six dogs who could sniff cannabis. So it's no wonder what happened. I'm happy that it had such a small outcome (10,000 heroin addicts in Amsterdam). It could have been much much worse."

Koos Zwart — a DJ with a difference

But while the sale of heroin is fraught with danger and violence, the over-the-counter cannabis trade in Holland is, by comparison, ironic, unpredictable, and even slightly comic.

As Zwart explains it, before 1968 every interest group in Holland, besides having its own radio programming, also dotted the country with youth clubs which were tied ideologically and financially with the parent association.

Zwart, who co-founded the first non-aligned youth club in 1968 in Amsterdam, also managed to procure government support for its diverse program of cinema, music, dance, and creative workshops. Called Paradiso, the club eventually led to the formation of 70 other clubs in Holland.

Its managers allow the use of cannabis on the premises while its sale by "house dealers" eliminates dealer crowding and ensures good quality.

Ministry of culture grants cover only rent and employees' salaries, continued Zwart, who says he left Paradiso when hard drugs came to be used there. He now sits on the advisory board of The Milky Way, one of five Amsterdam youth clubs. Entertainment costs at these clubs are covered by the sale of beer and admission prices.

Periodically, the clubs are raided by police and if the quantity of drugs taken is significant, government funding ceases and some close down. "That's life," Zwart shrugs.

But it seems that in this game of nerves between dealers and police, the unwritten laws are more adhered to than the written ones. Although everyone knows about house dealers (certainly anyone listening to "In de Rooie Haan") the police only raid when a club is brazen enough to advertise the fact, or when police are certain of seizing at least five kilos. Less than that, notes Zwart, just means unwanted paperwork at police headquarters. For pure irony, The Milky Way is across the street from a police station.

The comedy comes with Mickey's Marijuana Boat. If the name doesn't make you smile, the boat will. Moored on one of Amsterdam's many canals — but sufficiently off the beaten track — the boat's upper deck is thick and wavy with marijuana plants. The boat is painted in wild and gawdy colors and on its flagpole the stars and stripes flutter gloriously.

You enter through a huge pink and red mouth serving as a door, passing first a sign with a familiar leaf emblem. In the boat's belly is a lounge and at one end a wicket where cannabis is sold over a counter. The long-haired agent there redirects all questions to 'Mickey' himself, prostrate on the room's only bed, his arm in a sling, the result of a shooting. Discretion forbade my asking whether the wound was inflicted in the call of duty.

The use of cannabis, Zwart maintains is widespread in Holland. He believes that one in seven people is at least a one-time user, and he refutes studies which focus on cannabis use among students alone.

He also notes that while in 1968 a police seizure of 50 kilos of cannabis was considered sizeable, "they don't even wink at boatloads of 4,000 kilos now." Last year, he claims 7,000 kilos of marijuana were taken by Amsterdam police.

Since the new drug laws were passed last year, defining a dealer as anyone possessing more than 30 grams of cannabis, Zwart estimates about 100 people have been arrested. While dealers are liable to four to eight years in jail, users rarely receive the 500 gilder fine or the alternative 30 days in jail.

These new laws, now into a four-year test period, may be changed again when that time runs out. If they do change, Koos Zwart will probably play a role in deciding how. He already has political support for his plans to distribute free heroin, while Holland's 70 youth clubs owe something of their existence to his initiative.

Even the amendment to the new Dutch drug laws permitting an educational opiate permit was his doing. He convinced the Dutch minister of health — who happens to be his mother — that such an amendment was worthwhile and she intervened on his behalf in parliament.

And so Koos Zwart goes on the air every Saturday as he has for seven years ... "Lebanese Red — three gilders forty; Moroccan — three forty-five; Colombia — three seventy-five, India Temple — four eighty ..."

Norwegians invest $5.4M for Burmese crop switch

By Thomas Land

OSLO — Norway has decided to contribute 29 million croner ($5.4m) from development aid funds to the United Nations Fund for Drug Abuse Control to be invested in a crop substitution program in Burma over the next five years.

Parts of Burma, Thailand, and Laos make up the notorious Golden Triangle region of Asia which together produce roughly 500-600 tons of opium a year; much of which finds its way to the desperate black markets of northern and western Europe as heroin-3 or "brown sugar".

The contribution of Norway, which breaks the established pattern of world finance for drug abuse control, was announced simultaneously here and in Geneva, the headquarters of the UN drug abuse control fund. It is believed that the other Nordic countries are also likely to make significant new contributions to the fight against drug abuse.

During the first four years of its existence, the UN fund has received $15m from the United States, $608,000 from Canada, $355,000 from Britain and small token donations from other countries.

Knut Frydenlund, the Norwegian minister of social affairs, believes that his country's initiative "will undoubtedly mean a considerable strengthening of the activities of the UN drug abuse fund and could lead to other countries increasing their contributions and to new countries joining the effort.

"This would then be the beginning of an increased and coordinated international effort in the fight against drug abuse ... At the same time, farmers in the areas where production is substituted should be secured legally and economically, which is likely to increase food production. A better use of development funds could hardly be found."

The official statement issued jointly by the UN fund and the government here says that Norway is focusing on Burma as the largest individual country producing raw materials for heroin and hopes other nations will make a similar effort.

The UN/Burma program for drug abuse control officially began in May, 1976, with the signing of a formal, five-year agreement covering agriculture, health, social welfare, and education, and designed to curb illicit opium production and local drug abuse. The implementation of the project, however, has been hitherto postponed pending the availability of cash.

J. G. de Beus, executive director of the UN fund, said in Geneva the success of a crop substitution project in progress in Thailand has shown that the peasants of the Golden Triangle are ready to stop growing opium poppies — "risky," as he put it, "and not so profitable to them" — as long as they are given a decent alternative livelihood.

He expects tough opposition from the warlords of the Shan region of the Triangle who defy the authority of all three local governments because the illicit drug trade ensures them funds for maintaining their private armies. But the Burmese administration has recently made some military advances against the Shan warlords. "The general feeling of the region," says Dr de Beus, "is that opium production must be stopped."

Suppression of poppy growing in the notorious Triangle may thus promise a lengthy and bitter confrontation between the governments of the area and the traffickers. Specialists hope technological development in reconnaissance may perhaps tilt the balance in favor of law enforcement some time in the future.

They point to Turkey, until recently an important source of illicit opium supplies, where the government is now confident the entire national poppy crop is being used for the manufacture of medicinal opium. As a special safeguard against illicit cultivation, the UN has made available to Turkey two photo-reconnaissance aircraft using multi-spectral cameras which identify poppy fields in red.

The technique was devised in Mexico, a source of illicit opium for the United States and Canada, where helicopters spray the patches of ground with herbicides. In Turkey, illicit crops are destroyed by fire or slashing. But the photo-control system needs to be developed further for profitable use in the Triangle because the poppies are usually grown there in small patches between trees and scrub.

Norway's big financial contribution is the first practical response by Western Europe to the challenge of an elusive and highly efficient network of Chinese heroin traffickers which recently replaced the French Connection by capturing the illicit drug markets of the region.

The Nordic Council recently decided in Helsinki the most effective way to combat drug abuse was to go to its source with a joint program to prevent production. Additional contributions are therefore expected from Denmark, Finland, Sweden, and Iceland which, together with Norway, have more than 10,000 "potent" drug addicts, according to police estimates.

Around the World

Irish problem

There is an urgent need to change Irish "socio-cultural standards" to help cut down heavy drinking, Cardinal Conway, the Primate of Ireland, said recently. Excessive drinking and the alcoholism that resulted from it were among the greatest social problems facing Ireland today, he said.

Chemical workers

The alcoholic drink and tobacco industries in the United Kingdom employ 134,200 people — more than half of them in the production of beer. John Golding, under-secretary of state at the department of employment, told the Commons there were 69,100 employed in the British brewing and malting industries at August 1976; 32,000 in "other drink industries"; and an estimated 33,100 employed by the British tobacco industry.

Health Tax

Concerned at the effect that drinking and smoking are having on the country's health services, the New Zealand Government has imposed a "health tax" on alcohol and tobacco. In his latest Budget, the Prime Minister and Minister of Finance, Robert D. Muldoon, added 1 cent each to the price of a pack of cigarettes, a standard glass of beer, and a nip of spirits.

"The Government is concerned at the high level of public expenditure caused directly and indirectly by the consumption of tobacco and alcohol," he told parliament. The extra revenue — $US26 million in a full year — would "help sustain the high level of spending on health."

Swiss giant is singled out at UK science meeting

'Subtle propaganda' for psychoactives

By Alan Massam

LONDON — The ever-growing use of psycho-active drugs — and clear indications they are being overprescribed by family physicians in Britain — was a key issue at the British Association for the Advancement of Science meeting at the University of Aston in Birmingham.

The nettle was grasped by University of Reading psychologist David Warburton who told the conference he was very concerned about the television advertising of drugs by pharmaceutical companies.

Dr Warburton particularly singled out the giant Swiss company Hoffman la Roche which, he said, was estimated to have spent £220 million on the promotion of the tranquillizers Valium and Librium.

"Valium is recommended for psychic tension while Librium is supposed to be better for anxiety, but the distinction between the two is trivial and some would say non-existent.

"However, since the incidence of pathological anxiety is small the company has extended the use of its products by widening the definition of anxiety and persuading doctors to prescribe for the slightest symptoms."

Dr Warburton said about 19% of women and 7% of men were prescribed tranquillizers during any one year in Britain and the rate of use was increasing.

Some of the increase was as a result of people being helped where they could not have been treated successfully before but, in the vast majority of cases, the compounds were being prescribed for conditions that would respond to simple reassurance or would improve spontaneously.

"This is internal pollution and results from drug advertising to doctors," Dr Warburton claimed.

Dr Warburton added that as well as advertising to doctors which suggested that drugs were appropriate for the minor mood swings and tensions of life, a similar message was being promoted to the general public.

Manufacturers of over-the-counter drugs were producing propaganda to this effect. For example, the makers of aspirin products were suggesting it was a panacea for every kind of tribulation, not only the common headache.

"One-minute soap operas on television and strip cartoons in magazines and newspapers chart the progress of a father or mother becoming tense during a normal day's fight with life and then the magical relief of tension after the aspirin pill has been popped," he said.

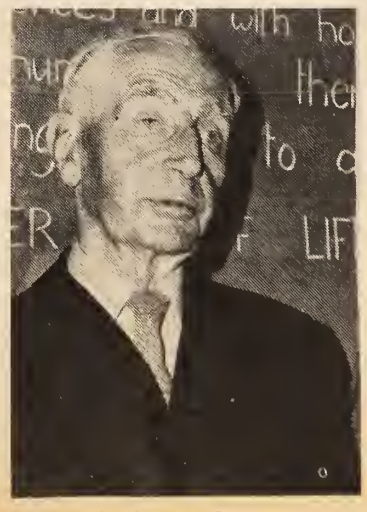
"The moral of these real life dramas is that even trivial psychological discomforts are not worth bearing since they can be erased with drugs so easily.

"In a competitive society, a person cannot afford to be even slightly unwell; and so lose a yard in the rat race through ill health."

The speaker added that "constant propaganda" had generated the idea that doctors could deal with psychological problems by means of drugs.

Pope honors NZ alcohol pioneer

AUCKLAND, NZ — Sir Charles Burns, consultant physician to New Zealand's National Society on Alcoholism and Drug Dependence, has received a papal knighthood. The rare award, which admits Sir Charles to the Order of St Gregory the Great, is in recognition of his service to the Catholic Church and his work for alcoholics.



Sir Charles Burns

British liquor and wine sales are poleaxed by the chancellor

LONDON — British doctors and field workers engaged in the unending struggle against alcoholism have found a potent ally in the cherubic form of Chancellor of the Exchequer, Denis Healey.

The chancellor's tax increases imposed last December have had a traumatic effect on home sales of liquor. In fact, the expression Scotch-on-the-Rocks seems now to have a double meaning.

Overall, consumption of home-produced spirits has slumped by nearly 30%, department of trade statistics for the last quarter have shown.

Douglas Messenger, deputy chairman of the Wine and Spirits Association, said the sales slump had been "traumatic."

He blamed Mr Healey's 10% regulator surcharge which put 31p on the price of a bottle of whisky, crashing it through the £4 ($8) a bottle barrier.

The standard bottle of whisky now costs the thirsty Briton an average £4 10p of which £3 15 is duty and 25p Value Added Tax. This leaves the profit margin for Scotch so low distillers say it is "quite inequitable."

But all is not gloomy for the distillers. As Douglas Messenger pointed out, with the drop in sales of spirits came a £30 million reduction in Customs and Excise duty revenues.

Despite the undoubted advantage in terms of costs within the National Health Service (drink is said to account for 10% of all deaths and injuries on the road as well as the growing cost of alcohol-related diseases) Mr Healey might well be persuaded to adjust the tax to level out these duty earnings.

For the present, however, it seems obvious the British social drinker has been severely hit by inflation. There are signs that women are switching from gin and tonic to lager while men are forgetting whisky in favor of dry vermouth.

Mr Messenger said: "Now the pound is worth less and drink costs more, people obviously have to spend the family budget on the necessities of life, so there is a certain trading down and they are buying the less expensive types of drink.

"Dry vermouth sales, for instance, are doing well. The fact that it is the dry white rather than the sweet which is selling suggests it is not just the women who are going on to it, but that there is actually a switch of masculine drinking habits."

"Beer sales are going down rather than up because, let's face it, we had an exceptional summer last year which hasn't been repeated. Everything is going down market towards the cheaper drinks."

The one boom drink, however, is lager which has grown from 10% to 25% of beer consumption in the last 5 years.

Kiwi mobsters take over

AUCKLAND, NZ — Hardened criminals are now running the New Zealand narcotics trade as a well-financed and highly lucrative business, according to the Customs Department.

This statement in the department's annual report to parliament gives official recognition to a radical change in the burgeoning drug trade here. Before last year, when it became apparent that underworld elements had entered narcotics trafficking, drug smuggling into this small South Pacific country was chiefly confined to marijuana, in fragmented quantities.

Now, the department says, the "hardened criminal element" is well organized to smuggle large shipments and it appears there is no lack of capital to finance ventures. It is also clear there is an illicit drain of New Zealand's overseas funds to pay for importing narcotics.

The report particularly mentioned the Straat vessels, which run a regular cargo service between South-east Asia and New Zealand and drop both narcotics and conventional contraband off the New Zealand coast.

Antagonist shows a limited promise among motivated

CAMBRIDGE, MASS — Use of a narcotic antagonist like naltrexone does show promise in a small group of patients who are relatively opiate-free, and well-motivated to seek treatment.

This was the conclusion in a report of the National Research Council Committee on Clinical Evaluation of Narcotic Antagonists, to the 39th annual scientific meeting here of the Committee on Problems of Drug Dependence.

However, at the same time, the committee to evaluate this treatment, which was chaired by Dr Leo E. Hollister of the Veterans Administration Hospital in Palo Alto, California, expressed some discouragement.

Differences between placebo and naltrexone, judging by retention in treatment, and opiate-free urine tests, were "slight".

The committee pointed out, however, that "the general experience in treating opiate-dependence has been that a single therapeutic episode has limited efficacy. Repeated attempts at treatment are required before the addict embraces and responds to any specific therapeutic program. Even then, complete abstinence may be an unobtainable goal. These considerations certainly apply to the use of narcotic antagonists, and perhaps create, in single studies such as this, an unwarranted pessimisstic view of their therapeutic potential."

In this multi-clinic study, men over 18 years of age were considered for the controlled trial, and classified in three group: 1) established "street addicts" recently detoxified; 2) former users now on methadone maintenance, and 3) "post-addicts" or former addicts currently drug-free after incarceration or participation in a therapeutic program.

Patients were randomly assigned to naltrexone or placebo, given in the form of a similar-tasting syrup, and given double-blind. Graduated doses of naltrexone were given daily, with the goal of 100 to 150 mg by the seventh day. After the first week, 50 mg medication was given Monday through Friday, and 100 mg on Saturday.

After eight weeks, patients were given 100 mg on Monday and Wednesday and 150 mg on Friday. It was hoped the patients would complete nine months of treatment. However, only 10 of the post-addicts, out of 205, three of the methadone group (out of 276), and none of the 254 street addicts, completed the full course.

Acceptance of the narcotic antagonist treatment was poor to start with, however. Of the 205 post-addicts selected, 113 dropped out before the study medication was started, while 218 of the 276 methadone-treated group did, and 212 of the 254 street addicts, at the five clinics.

The committee reported the attrition rate may have been enhanced by a protocol involving long periods for both study medication and for detoxification from methadone, in that group of patients.

"It does not appear as feasible, with the protocol used in this study, to mount a study of narcotic antagonist in a street addict or methadone maintenance population as it does with post-addicts."

While the antagonist effect of naltrexone is unquestioned, the committee report said, "the question was whether the addicts would be willing to sustain a heroin-insensitive state long enough to produce some improvement in their life-styles. With respect to the latter, subjective reports of the patients themselves were of little value. We were disappointed by the psychosocial data collected, both in measuring efficacy and in predicting outcome.

"Two objective criteria of the efficacy with which naltrexone decreased drug-seeking behavior were of some value in comparing the treatment and control groups. These were the length of time the patient remained in the program, and the frequency with which he took illicit drugs during the study, as measured by analysis of urine samples. Both such measures tended to support efficacy of naltrexone. A stronger support came from retrospective combination of these two criteria."

Participating in this study, besides Dr Hollister, were Drs Jacob E. Bearman, University of Minnesota; Troy S. Duster, University of California, Berkeley; Daniel X. Freedman, University of Chicago; Donald M. Gallant, Tulane University; Louis S. Harris, Medical College of Virginia; Murray E. Jarvik, VA hospital, Los Angeles; Donald R. Jasinski, Addiction Research Center, Lexington, and C. James Klett, VA Hospital, Perry Point, Md.

Elevator smoker lights up lawsuits

WASHINGTON — It began 18 months ago with one cigarette and what should have been a four floor elevator ride. A heated argument and two lawsuits later, it has not ended.

James Davis was smoking the cigarette when he entered the elevator in the District of Columbia Superior Court building in April, 1976. Smoking in elevators in Washington has been banned since 1975, but this particular one did not have a no smoking sign.

Lawyers Roy Licari and Donald Brown got into a heated discussion with Mr Davis about the cigarette.

Since then, Mr Davis has filed an $800,000 suit for injuries he said he received when the lawyers forced him to stay on the elevator until a building guard was found.

Mr Licari and Mr Brown, in a counter $20,000 lawsuit, claim Mr Davis assaulted them with the smoking cigarette causing harmful substances — they name 46 — to enter their bodies.

The elevator now has a no smoking sign. There is no sign of an end to the lawsuits as each party continues to maneuver in court.

Monkeys valuable in potential drug abuse evaluation

By Jean McCann

CAMBRIDGE, MASS — A "promising tool" to evaluate the reinforcing properties of drugs to determine their potential for abuse before they are used in humans, was described here to the 39th annual scientific meeting of the Committee on Drug Dependence.

Robert L. Balster of the Medical College of Virginia, told how rhesus monkeys were used "to compare the strength of various drug reinforcers to a non-drug reinforcer, food. Basically, the procedure involves giving catheterized rhesus monkeys 32 choices per day between food or intravenous drug reinforcement. The choice of one precludes obtaining the other on that trial."

First, the animals were given a choice between food and cocaine. At a dose of 100 ug/kg injection about half the animals preferred the drug, and at 300 ug/kg, almost all the monkeys chose cocaine over food at each opportunity.

Next, morphine, pentazocine, nalorphine, and cyclazocine were studied. The monkeys chose morphine an average of 12.1 times out of 32 at a 100 ug/kg level, and 9.9 times at 10 ug/kg/. With pentazocine, the comparable figures were 10.2 and 4.0, with nalorphine 0.9 and 3.0, and with cyclazocine 1.3 and 0.7, respectively.

When the choice was between food and saline, however, the monkeys chose saline only 0.8 of the 32 times.

On the basis of these tests, Dr Balster said "we would rank the relative reinforcing efficacy of these four compounds, in order, as morphine, pentazocine, nalorphine, and cyclazocine. This corresponds well with clinical experience and human testing" of these same drugs.

While this trial shows promise for testing opioid drugs whose reinforcing capacities are not as well known, there is a drawback, he said, and that is the time and expense involved. Animals must be trained in complex maneuvers of self-administration of the various substances over a long period, and the test itself takes at least several days for each drug.

"As a consequence of the difficulty of this test, it should only be considered as one of the last in a series of preclinical evaluations", Dr Balster told the meeting. "But it can clearly serve as an important part of an overall program of abuse liability evaluation."

Dr Balster's study was done in conjunction with Drs John M. Carney and Louis S. Harris, and Thomas G. Aigner.

Next month, Jean McCann reports from the NATO conference on Experimental and Behavioral Approaches to Alcoholism in Oslo, Norway.

Dutch alcohol expert feels rich in comparison

Canada chided for paucity of funds

By Manfred Jager

WINNIPEG — A Dutch psychiatrist who specializes in drug and alcohol addiction treatment predicted here last month that what he refers to as a worldwide epidemic of alcoholism is bound to continue its increase for some time to come.

However, all epidemics are eventually self-limiting, Tjeerd Jongsma of Groningen, The Netherlands, concedes.

By the time addicts, particularly alcoholics, decide to seek help, they will usually have been dependent on alcohol for 10 to 15 years, Dr Jongsma said. This means a decrease in the level of alcohol dependency won't be noticeable until at least a decade after it occurs.

Dr Jongsma, an associate psychiatry professor at the University of Groningen's medical school until this summer, is now medical director of three Groningen therapeutic communities with a combined capacity of 100 patients.

He told **The Journal** he finds it hard to understand why Canadian treatment facilities for alcoholics have such difficulty obtaining government financial support, and why medicare doesn't pay for addicts' treatment in such therapeutic communities as the X-Kalay Foundation in the Winnipeg suburb of St. Norbert.

"There is no doubt about it," Dr Jongsma said, "we are ahead of you in our country. I don't want to sound as if I'm boasting, but when I look around here, I feel like a rich man as far as treatment facilities back home are concerned."

Holland, as most of the rest of the world, has about 10 times more alcoholics than other drug addicts, Dr Jongsma said, and treatment facilities are spread all across the country and can be reached without difficulty.

"I find that we have far more opportunity to get money from the government and develop new treatment programs than agencies here or in the United States."

Dr Jongsma said both the medical-professional community and the public still are too conservative in their approach to alcoholics and their treatment. The professionals must admit that people without medical or other health degrees can effectively treat and rehabilitate alcoholics. The public, meanwhile, must stop thinking of alcoholics simply as sinners against the health of the fabric of society.

"There has always been an undercurrent moralistic attitude, with people looking at alcoholism and that type of behavior as sin," Dr Jongsma said.

"It's part of a stereotype to keep unpleasant things far in the distance so you don't have to deal with them and you think you're safe. People themselves involved with liquor may admit they drink too much, but they won't admit that they are alcoholics even if they depend on liquor. They'll say, yes, I drink, but I can handle it. I can take it or leave it.

"If there is one thing we have learned about the potential causes of alcoholism, it is surely that nobody becomes an alcoholic because he is leading such a very happy life. There always are problems, tremendous unhappiness, sadness, and tragedy behind alcoholism — things befalling people which they then can't deal with in the most effective way."

Direct causes of alcoholism vary and are multiconditional. It is not likely that science will eventually decide one cause is the key, the psychiatrist said.

He said therapeutic communities such as X-Kalay have evolved since the late 1950s and will continue to be one of the more successful and effective means of rehabiliating alcoholics and other addicts. Their number will continue to increase and their treatment will evolve or even change drastically, but their philosophy will remain unchanged.

These communities seem "reasonably" strict, he said. But beyond that "they are warm and open communities, where people truly care for each other and develop the ability to show they care and want to help each other and prevent people from feeling lonely and running away again instead of starting new lives."

Therapeutic communities probably will become one of the mainstreams of treatment for addictive behavior disorders linked up with feelings of loneliness, failure, and disillusionment, Dr Jongsma said.

Despite the anticipated self-limiting characteristic of the alcoholism epidemic around the world, the Dutch psychiatrist said he remains a pessimist.

"I am not optimistic. I think we will continue to face an increase in the level of alcoholism, particularly under welfare state conditions where even the unemployed have of course the choice to spend part of their assistance on alcohol."

Asked what would happen if public opinion turned 180 degrees and from increasing liberalism to increasing punitiveness, he said:

"I don't think there would be a decrease in alcoholism.

"A few people would stop drinking and a few crimes would not be committed. But the hardened alcoholic would continue to drink, and some of the hardened alcoholics would no doubt commit crimes.

"They are the people who would be willing to face the gallows, if caught, because they are very depressive and self-punishing about themselves and subconsciously feel they must gamble and seek punishment. They kind of need that strong stimulation of risk and danger."

$15 to tow a drunk

WINNIPEG — A Winnipeg towing company has started a 24-hour Tow-A-Drunk service similar to those in operation in Ontario and British Columbia.

For a flat rate of $15, the company will drive home Winnipeggers who have had a few too many and feel they might be in trouble, courting injury, death, or the wrath of the law if they are caught. The towing firm will drive them home and tow their car to their house at the same time.

The service started in September and is available 24 hours a day, seven days a week. Printed cards advertising the service have been placed in night clubs, hotels, restaurants, pubs, and other places where people either buy or consume alcoholic beverages. Advertisements have also been placed in Winnipeg's two daily newspapers.

The towing company says its rate for inebriated customers applies anywhere within city limits. The firm has 32 radio-dispatched tow trucks and 24-hour fenced storage facilities.

A similar service has been available in Oshawa, Ont., but business there was quiet for the first few weeks.

opiates opiates opiates opiates

factsheet

Opiates originate in the juice of the oriental poppy (Papaver somniferum). The group includes opium and its constituents, codeine and morphine, for example, as well as their derivatives, such as heroin.

These opiates, and related synthetic drugs such as meperidine (Demerol) and methadone, are often called narcotics. They are used in medicine to effectively relieve acute pain resulting from surgery or injury and during the later stages of terminal illnesses such as cancer.

The opiates have been used both as a medication and for pleasure since prehistoric times. For centuries, people drank a tincture of opium called laudanum for sedation or to depress coughing or counter diarrhea. By the mid-19th century, morphine had been isolated in a pure form which could be used in the preparation of solutions. With the introduction of the hypodermic needle, injection of these solutions became the common way to take them. Today, of the 20 components of opium — the alkaloids — only morphine and codeine are still in widespread clinical use.

Heroin (dicetylmorphine) was derived in 1898 as a remedy for morphine addiction. Although it proved to be a better painkiller (analgesic), it was far more addictive than morphine. Each of the synthetics, in turn, was developed to provide an analgesic without addicting properties but all of them are capable of producing dependence.

However, research has resulted in the development of another family of drugs, called narcotic antagonists (eg Naloxone). These are used in emergency medical treatment, not as painkillers, but to reverse the effects of opiate overdose resulting from over-medication. Narcotic antagonists block the euphoric and physiologic effects of the opiates. It is this ability that holds promise of a non-addicting way to treat street drug addicts, as well. At the moment, clinical research is continuing in this area.

On the street, opium is usually seen as dark brown chunks or powder. It is eaten or smoked. Other narcotic analgesics come in various colors, usually in the form of capsules or tablets. Syrups, elixirs, solutions, and suppositories are also available. While some of these forms may be sniffed, taken orally, or rectally, the solutions are usually injected under the skin, into a muscle, or into a vein. Methadone is a long-lasting synthetic narcotic painkiller which is highly effective when taken orally and is now commonly used in the treatment of drug addicts.

EFFECTS

Opiates briefly stimulate the higher centres of the brain, then depress activity of the central nervous system. The precise effects depend on the specific drug as well as the dose and the way it is taken, the previous drug experience of the use, the setting in which it is used, and personal characteristics of the user.

In a therapeutic setting, the usual dose of morphine lasts about three to four hours. During that time, although pain is still perceived, the reaction to it is weakened. A state of contentment is achieved since the narcotic brings detachment from concern and freedom from distressing emotion. In a person who is not experiencing pain, these drugs may cause restlessness and discomfort.

Short term effects are those which appear rapidly after a single dose is taken and disappear within a few hours. The illicit user often seeks a "rush" (a surge of pleasure) then a "fixed" state of gratification into which hunger, pain, and sexual urges do not intrude. The dose required may initially cause nausea and vomiting.

With moderately high doses the body feels warm, the extremities heavy, and the mouth dry. Soon the user goes "on the nod," an alternately waking and drowsy state during which the world is forgotten.

As the dose is increased, respiratory depression becomes progressively more marked. With very large doses the person cannot be roused, the pupils are contracted to pinpoints, the skin is cold, moist, and bluish, and profound respiratory depression may result in death. This is a particular risk on the street, where contents of a "hit" cannot be accurately gauged.

Long term effects are those provoked by repeated use over a long period of time. It has been suggested that dependence arises when, as a result of drug use, physiological, biochemical, social, or environmental forces make one susceptible to continued drug use.

Two syndromes closely associated with opiate dependence are tolerance and withdrawal. Tolerance, the mechanism whereby larger doses are needed to achieve the desired drug effect, is not clearly understood. It may be that opiates interfere with the transmitter-receptor system in the brain, and cells adapt to function normally in the presence of increasing amounts of the drug. This results in increased sensitivity to any stimuli when the drug is withdrawn.

Withdrawal from the drug for a short time produces uneasiness, yawning, tears, and a runny nose, along with a "craving" for the drug, the use of which brings pleasurable relief. Severe withdrawal effects peak between 48 and 72 hours after the last dose, and subside over a week. Some bodily functions do not return to expected normal levels for as long as six months. Sudden withdrawal by heavily dependent addicts who are in an unhealthy condition has occasionally been fatal.

Addiction-related illnesses include:
a) Endocarditis — organisms, introduced into the body by drug injection, affecting the valves of the heart;
b) Pulmonary complications — including pneumonia of various types;
c) Tetanus, seen most often in women with a long history of subcutaneous injection (skin popping);
d) Abcesses, cellulitis, liver disease, and possibly brain damage resulting from the infections associated with the practices and lifestyles of those who inject opiates regularly.

TREATMENT

Medical treatment is necessary for severe withdrawal states and for addiction-related illnesses. Historically, methods of dealing with people dependent on opiates have ranged from imprisonment to hospitalization. Britain has traditionally provided legal opiates where this has been considered the most medically appropriate course for the patient. Since 1968, British clinics attached to teaching hospitals have administered the programs within a total treatment setting. In Canada, only methadone can be so prescribed, and since 1972 only certain physicians have been authorized to do so.

In withdrawal programs, methadone is used with the initial goal of ending narcotic use. Methadone maintenance programs aim to stabilize the addict on methadone while therapy proceeds. Ideally, criminal involvement ceases and the personal and vocational situation improves, so that eventually a drug-free existence can be attained. Opponents of such programs claim the patient becomes addicted to yet another substance and sometimes leaks methadone into the illicit street market.

Therapeutic communities — such as Stonehenge in Ontario and Synanon and Daytop in the United States — radically restructure the user's lifestyle. A few of the communities involve former addicts in the treatment process. Some hospitals now use behavior modification approaches as well as group and individual therapy in both inpatient and outpatient services. Research into the use of a narcotic antagonist as "protective" medication continues.

No one treatment has been found appropriate for all. It is not only the substance which induces dependence; the ritual associated with injecting the drug fascinates some addicts. Such a complex phenomenon will continue to require multi-faceted treatment, although evidence shows that some young users stop abusing opiates as they mature.

WHO USES OPIATES?

Opiate use and opiate dependence should be differentiated since not all users become physically dependent on the drug. Occasional heroin users, sometimes referred to as "chippers", report intermittent use without developing physical dependence.

A small proportion of those for whom opiates have been prescribed in medical treatment become dependent. Even codeine use continued inappropriately can get out of control. In such cases, medical advice should be sought since withdrawal symptoms can result from abruptly stopping use after physical dependence has been established. People who become dependent as a result of medical treatment are referred to as "medical addicts." The "professional addict" is one who becomes dependent while a member of the medical or allied professions where the availability of the drug is high. However, the largest proportion of opiate abuse falls into the "illicit" category.

In the last few years, synthetic narcotics such as hydrocodone, hydromorphone, oxycodone, and meperidine have gained prominence as drugs of dependence. Physicians are sometimes pressured to provide prescriptions for these medications. They are also stolen from pharmacies, sold on the street, and used illegally.

In terms of dependent people in treatment, the ratio of male to female has remained consistently two to one.

OPIATES AND THE LAW

The federal Narcotic Control Act regulates the possession and trafficking (which includes selling, giving, or sending the drug to another person) of all opiates. This act permits individual physicians, dentists, pharmacists, and veterinarians, as well as hospitals, to keep supplies of opiates. The public must obtain these drugs from such authorized sources. It is no longer legal to prepare or import heroin into Canada. Cultivation of the opium poppy is also on offense.

The penalties for violation of the Narcotic Control Act vary according to the offense committed. Unlawful possession or cultivation can result in a prison sentence of up to seven years. Possession for the purpose of trafficking can result in a sentence of up to life imprisonment. Importing or exporting opiates without proper authorization calls for a minimum sentence of seven years and a maximum of life imprisonment.

The Journal

This page is presented as a service to our readers. The text of the above is available in a smaller format, and can be obtained for minimal cost from: The Marketing Department, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Clip out this page

New Books

by RON HALL

Drugs, Rituals And Altered States Of Consciousness

. . . edited by Brian M. Du Toit

This edited work contains 15 chapters which range from a theoretical introduction to a number of descriptive chapters and includes some important discussions for applied social sciences. Studies range from drug use in South Africa and South America, to street scenes in modern American cities. The theme of ritual, both sacred and secular, runs throughout. Chapters deal with hallucinogens, cannabis, alcohol, heroin, methaqualone, and polydrug complexes.

(A. A. Balkema, ISBS, Inc., PO Box 555, Forest Grove, Oregon, 97116. 1977. 282p. 16.50)

Guidelines For Information Programs

. . . by Lesley Barnes and Pat Crawshaw

This document emphasizes how to use existing information; how to plan, design, and evaluate information programs; and how to expand one's knowledge base so that related information can be introduced into program design to reinforce the examination of attitudes, beliefs and behaviours. It is in the form of a "programmed learning" text with each section divided into component parts with review questions. There are four major sections including: a discussion of the philosophy and standards necessary for the development of any information program; a section dealing with elements to be considered prior to implementation; one which addresses elements which comprise the actual implementation; and a fourth concerning those elements which allow staff to assess the impact on participants. It also includes a bibliography, several appendices, and a series of definitions relevant to information programs. The Commission hopes to stimulate curiosity and a desire on the part of readers, who wish to use the "Guidelines", to add further modifications and refinements.

(Nova Scotia Commission on Drug Dependency, 5871 Spring Garden Road, Halifax, Nova Scotia, B3H 1Y2. 1977. 204p.)

Other Books

Drugs of Concern in New Zealand — Simpson, David. Welsh University of Waikato, Hamilton, 1976. Concepts; CNS depressants; narcotic analgesics; CNS stimulants; psychotomimetics; references. 87p.

Trip into Illusion: Misuse of Drugs by Adolescents — Wotzel, Horst. The Grail Message Foundation Publishing Company, Stuttgart, 1975. Extent of the problem; road to dependence; problem of dependences; human image. 68p. $10.

RX: 3x/week LAAM Alternative to Methadone — Blaine, Jack D., and Renault, Pierre F. (eds). National Institute on Drug Abuse, Rockville, 1976. Preclinical studies; clinical studies. 126p.

Understanding Alcohol and Alcoholism in Scotland — Scottish Health Education Unit, Edinburgh, 1975. Consumption; prevalence; causes; effects; prevention; treatment; references. 23p.

Environmental Design for Social Model Alcoholism Programs — Crowell, Christopher, Johnson, Thomas, Post, Howard, and Stolz, Nancy. Garden-Sullivan Hospital Social Setting Detoxification, San Francisco, 1976. Program description; spatial accommodation; design elements. $5.

Total Impairment Risk Factors — Warren R. A. Traffic Research Foundation of Canada, Ottawa, 1976, 26p. $3.50.

The Young Driver Paradox — Warren R. A., and Simpson, H. M. Traffic Injury Research Foundation of Canada, Ottawa, 1976. 12p. $3.

Adolescent Alcohol Education — National Council on Alcoholism, New York, 1975. "Proceedings of the Region III Conference," Lancaster Pennsylvania, February 1975. 106p. $4.50.

Directory of Projects (England and Wales) 1976/77 for Adult Offenders, Alcoholics, Drug Takers, Homeless Single People with Histories of Mental Illness — Chamberwell, Council on Alcoholism, Campaign for the Homeless and Rootless, Cyrenians, Mind, National Association for the Care and Resettlement of Offenders, and Standing Conference on Drug Abuse. Barry Rose (publishers) Ltd, Chichester, 1966. 277p. $85.00.

Gryphon's Guide to Overdose Aid — James, Hank, and Dulaney, Sylvia. Do It Now Foundation, Phoenix, 1976. Emergency information; basic skills; drug information; references. 40p. $1.25.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

The Young Drinkers

Subject Heading: Youth and Alcohol.

Details: 15 minutes, 3/4" videocassette, color, sound.

Synopsis: In 1971, the legal drinking age in Ontario was lowered from 21 years of age to 18. The videotape outlines many of the problems that have resulted from this Act. On-premise alcohol sales have increased as young people are seem more frequently in public drinking places. Alcohol-related driving accidents in this age group have increased by more than 300%. The videotape asks, would raising the legal drinking age to 19, help curb the present teenage drinking behavior?

General Evaluation: Fair to good (3.4).

Recommended Use: Adult audiences and special audiences such as politicians and legislators.

The PCP Story

Subject Heading: Drug Use: Etiology and Epidemiology, Drugs and Youth, Drug Pharmacology.

Details: 26 minutes, 16 mm, color, sound.

Synopsis: PCP in different doses, gives wide range of effects from mild anesthetic to hallucination to stupor. Users tell of their experiences and scenes are shown of overdosed PCP users being treated in an emergency unit. Acute overdoses can lead to disorientation, agitation, and violence. Accidental death and car accidents have been linked to the use of PCP.

Accuracy: Information acceptable. Pharmacological data on PCP limited.

General Evaluation: Poor-fair (2.6). Boring, of poor quality, a poor teaching aid.

Recommended Use: Because of lack of films on PCP, this could be used with audiences of 15 years and beyond.

Positions Available

ALCOHOLISM NURSE

For new, day program offering group, individual and family treatment approaches for alcoholics. (Some narcotic addiction work included).

Qualifications:
Registered Nurse
Considerable experience and education, specific to alcoholism.

Salary:
Commensurate with experience.

Please contact: Mrs. I. Desilets
Staffing Coordinator
ST. BONIFACE GENERAL HOSPITAL
409 Tache Avenue
Winnipeg, Manitoba, Canada R2H-2A6
Phone: 233-8563 Ext. 380

NZ looks into smoke habit

AUCKLAND, NZ — New Zealand's first hospital-based clinic to assess the problem of smoking and prescribe methods of treatment is to be set up in Christchurch as a result of a $40,000 grant from the National Heart Foundation. It will be under the control of John R. E. Dobson, of the department of psychological medicine at Princess Margaret Hospital.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Canada Safety Council — Oct 2-5, 1977, Halifax, Nova Scotia.

Detox Training Program — Oct 24-28, 1977, Addiction Research Foundation, Toronto, Ontario. Information: Diane Hobbs, ARF, 33 Russell Street, Toronto, Ont. M5S 2S1.

20th annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9.

United States

1st National Leadership Training Institute on Women and Alcoholism — Oct 3-6, 1977, The American University, Washington, DC. Information: Jan DuPlain, director, NCA Office on Women, 1925 North Lynn Street, Arlington, Virginia, 22209.

Empirical Approaches to the Treatment of Alcohol and Drug Abuse — Oct 13-15, 1977, Charleston, South Carolina. Information: Catherine Young, Department of Psychiatry, CSB, Medical University of South Carolina, 80 Barre Street, Charleston, SC, 29401.

6th annual meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 26-30, 1977, New York City. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

Perspectives in Psychiatry . . . the 1980s and Beyond — Oct 27-28, 1977, New York City. Information: Dean of the Clinical Campus, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York, 11040.

National Community Action Agency — Oct 29-Nov 3, 1977, Philadelphia, Pennsylvania. Information: Together Inc., PO Box 52528, Tulsa, Oklahoma, 74152.

Fetal Alcohol Syndrome Symposium — Oct 31, 1977, The Sheraton Inn, Madison, Wisconsin. Information: Wisconsin Association on Alcoholism and Other Drug Abuse, Inc., 333 West Mifflin Street, Suite 4, Madison, Wisconsin, 53703.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, PO Box 5115, Phoenix, AZ, 85010.

2nd Southeastern Conference on Alcohol and Drug Abuse — Dec 1-3, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington, 98122.

Joint Conference of the American Association for Automotive Medicine and 7th International Association for Accident and Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM Executive Secretary, PO Box 222, Morton Grove, Illinois, 60053.

Abroad

Workshops on Alcoholism in Scandinavia — Oct 4-18, 1977, Denmark, Norway, and Sweden. Information: New York City Affiliate Inc. National Council on Alcoholism, 730 Fifth Avenue, New York, NY 10091.

7th International Institute on the Prevention and Treatment of Drug Dependence — Oct 16-21, 1977, Lisbon, Portugal. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Special Symposium on Drug Dependence, 11th International Conference on Pediatrics — Oct 23-29, 1977, New Delhi, India. Information: Dr. O. P. Ghai, All-India Institute of Medical Sciences, New Delhi, India.

Asian Seminar on Research and Epidemiology on Drug Dependence — Nov, 1977, Chaing Mai, Thailand. Information: Professor Prasop Ratankorn, director, Drug Dependence Research and Prevention Centre, 268, Rama 6, Phyathai, Bangkok 4, Thailand.

3rd Arab International Conference on Alcoholism and Drug Abuse — Dec 3-7, 1977, Khartoum, Sudan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th Colombo Plan Consultative Committee Meeting — Dec, 1977. Information: The Colombo Plan Bureau, 12 Melbourne Avenue, Colombo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

International Conference on Alcoholism and Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute on the Prevention and Treatment of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

24th International Institute on the Prevention and Treatment of Alcoholism — June 25-30, 1978, Zurich, Switzerland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

32nd International Congress on Alcoholism and Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Clarification for San Francisco

TORONTO — The article "San Francisco is taking offence at NIDA report" in the August issue of **The Journal** (page 3) stated that researchers at the Haight-Ashbury Free Medical Clinic had determined that there are between 6,000 and 9,000 heroin addicts in San Francisco, and that NIDA (National Institute on Drug Abuse) had ascertained that the number of heroin addicts in the San Francisco area was 28,000 (916 per 100,000).

The figures are accurate, but comparison of the two studies could be misleading. In fact the Haight-Ashbury figures cover San Francisco alone, while NIDA's statistics deal with the four-county San Francisco Bay area.

David Smith, medical director at the Haight-Ashbury Free Medical Clinic says his researchers can neither confirm nor deny the NIDA figures for the four-county San Francisco Bay area since they have not studied the incidence of heroin addiction there. But they have expressed surprise that the incidence of heroin addiction is as high as the NIDA figures indicate.

Further, Dr Smith notes that even if there were methadological errors in the NIDA study (as some have claimed), the same errors would have been made in all cities in the United States examined, and NIDA's ranking of the San Francisco area as the metropolitan area in the US with the highest per capita incidence of heroin addicts would still be valid.

The latest figures from the Heroin Epidimiology Research Group at the Haight-Ashbury Free Medical Clinic indicate the number of active heroin addicts in the city of San Francisco has dropped from about 6,000 in mid-1976 to about 5,000 as of late May, 1977.

Five indicators — overdose deaths, burglaries, emergency room incidents, hepatitis, and "street wisdom" each suggest a sharp decline took place between early 1976 and early 1977 in the number of active heroin addicts.

Three other indicators — treatment caseload, year-of-first-addiction data, and public survey data — are more consistent with a "no change" hypothesis. Two other indicators — urinalyses and heroin sample analyses — were considered unrealiable.

ALBERTA:

A roller coaster world of affluence, alcoholism

By John Shaughnessy

Sleeping it off in front of Calgary's Board of Education building.

FRED DOESN'T look like a skid row alcoholic. He's in his mid-forties, tall and strong, with a face that's been weathered by hard outdoor work.

His coveralls are clean and he's in good physical shape. But, it's 10 o'clock in the morning and he's on the street trying to separate patrons of the Calgary Inn from their change so he can put together the price of a mickey of rum.

The alcoholics sleeping it off or sharing a bottle on the lawn of the Calgary Board of Education building fit the skid row scene. Not Fred. He stands out, apparently strong and confident. Yet, his problem is there.

In a way, Fred personifies Alberta in 1977. Strength, vitality, and growth are the dominant characterisitcs, but they are not the only ones. Personal and social ills form part of the picture too.

For most Canadians, Alberta spells affluence.

And with good reason. The province has the highest labor participation rate in Canada; unemployment last year was a mere 3.9%; and taxes are the lowest in the country. There are neither sales taxes nor succession duties and income taxes are 20% lower than anywhere else in Canada.

Maclean's magazine last spring called the province "Camelot West" and many Canadians seem to agree. For the past five years, newcomers have moved into the province's two major cities, Calgary and Edmonton, at the rate of about 1,000 a month. Some are looking for money; others want to be where the action is; still others are searching for their personal utopia.

Not all are successful in their quests.

Alberta's rates for alcoholism, suicide, divorce, and crime are among the nation's highest, and some experts predict they are likely to climb higher because of rapid economic growth, urbanization, and the influx of newcomers.

Some underprivileged groups, such as the native peoples and welfare mothers have been untouched by the new affluence. Others, such as the elderly, may have been harmed by it — the social services provided to care for them create many of the situations that predispose to alcohol abuse.

No one knows precisely how many Albertans have alcohol problems, but Wilf Totten, executive director of the Alberta Alcoholism and Drug Commission, suggests 5% of the population would be a rough indication.

"Using that measure, we have about 90,000 people who are either alcoholics or pre-alcoholics, candidates for some type of treatment or intervention."

Another measure, per capita consumption of alcohol, reinforces the impression. Among the provinces, Alberta is second only to British Columbia on this score. If one accepts the theory that the incidence of alcohol problems rises with per capita consumption, the image of Alberta as a new utopia begins to fade.

Mr Totten says that last year the liquor control board turned over to the provincial treasurer something in excess of $100 million. "But if you consider all the costs of alcohol related problems I'm sure the government lost money.".

AADAC itself has a budget of about $7 million for the current year — about $3.50 per capita — to run its many education, treatment, and rehabilitation programs. Other agencies, such as the National Advisory Board on Native Alcohol Abuse are financed by the province and/or the federal government; still others are privately run and funded.

"Compared with other provincial programs we're reasonably well endowed," said Mr Totten. "There's always the question of whether you have enough money. If you say you don't, the implication is that with more money you could do a better job, but I'm not sure that's true. Money alone won't solve the alcoholism problem."

A quick look at the list of addiction related services available seems to bear this out. In the province's five regions — North, Edmonton, Central, Calgary, and South — AADAC and its cooperating agencies provide community services in 15 centres; Edmonton and Calgary both have detoxification centres; one provincial hospital is devoted to alcohol and drug abuse; 13 centres serve as the bases for the province's impaired drivers' program; AADAC runs three in-patient facilities and 14 out-patient clinics; the National Advisory Board on Native Alcohol Abuse funds programs in 16 centres; and AADAC itself funds another 25 programs run by outside agencies.

The province's commitment to reducing the damage done by alcohol and drug abuse cannot be denied, but efforts have so far had limited success.

"We simply don't have the answers to the problem," said Mr Totten. "For example today there is a big debate about the homogeneity and/or heterogeneity of addict populations. But with the advent of polydrug abuse we've adopted the attitudinal stance that we are dealing with intoxicant abuse and abusers. At least in terms of treatment centres, we favor a general approach rather than devoting our resources to the treatment of addictions to specialized substances or special subgroups of abusers.

Whether this policy stance is appropriate is a moot point, but it is clear that in Alberta, alcohol and drug related problems cannot be simply categorized.

Among its 1.8 million inhabitants, Alberta has 35,000 status Indians and another 70,000 to 90,000 Metis or others who espouse the Indian culture. Yet 60% of the inmates in Alberta's correctional institutions are native people, and almost all of them are there for liquor-related offences.

Ed Crowshoe, a counsellor at the Native Alcoholism Services out-patient centre in Calgary, says quite bluntly that whites cannot successfully counsel native alcoholics.

"The Indian is trying to cope with two cultures, his own and the white man's, and the white counsellor can't really understand what he's going through. For years the Indian has been programmed to feel inferior, and in a counselling situation where he has to use a language not his own, where his appearance and behavior differ from the white man's these feeling are reinforced. The native person's self respect, his pride in being an Indian, will not be strengthened and he will remain shy and close-mouthed about his true feelings and problems."

Mr Totten acknowledges that cultural factors are important in treating the native alcoholic, but he thinks relating the problem to them as natives does them a disservice.

"As an ethnic group, the natives tend to be underprivileged, the opportunities for them to be 'successful' in white man's terms are not nearly so great as they are for us. But if you compare the rate of native alcoholism with the rate for other underprivileged groups in white society, the difference is not that great."

In Alberta, as in other parts of the country, there is also an increasing awareness of alcoholism problems among women. But to date, few specialized treatment facilities are provided.

"We don't have a conscious policy of segregation," said Mr Totten. "We try to adopt the general posture that we are dealing with problems of intoxicant abuse and abusers. Sex, religion, nationality are factors, but we consider them secondary in our overall attitudinal stance."

Riverside Villa in Calgary is the only AADAC program devoted exclusively to women. An 18-bed in-patient facility, it surprisingly has never been filled to capacity. Recently the number of beds was reduced to 12 and AADAC is attempting to arrange a referral scheme with neighbouring Saskatchewan so the facilities will not go to waste.

The absence of women is also evident at the Renfrew Detoxification Centre in Calgary. Located in a middle class residential area, the centre allocates less than 10 of its 30 available beds for women. Marg Silver, former director of the centre, says the women's dorm is rarely filled. Usually only one or two women are in the program.

Throughout the province, four to 10 times as many men as women are receiving treatment and rehabilitation in "coed centres", according to Mr Totten. "It could be argued that these centres are not really 'coed' at all, and it may be a weakness that we haven't set up more programs exclusively for women. On the other hand, that argument can be taken too far because women don't live in the world by themselves."

The general approach is being used to deal with teenage alcoholism as well. There is one program specifically for teenagers run by a Catholic priest in Edmonton but otherwise no separate facilities are available.

THE BACK PAGE

As in other provinces, the increase in teenage drinking has prompted some groups to push for a raise in the drinking age.

In a recent telephone survey in Red Deer, 60% of the respondents favored an increase in the drinking age. Twice a private member's bill to have the drinking age increased has been introduced into the provincial legislature, but both times it died on the order paper.

Officially AADAC is against any increase. "We think in the long run such a move would be terribly inconsistent since the age of majority is 18," said Mr Totten. "We don't think it would solve our problems either. If we're going to use an age classification, we might as well make the minimum age 35 and the maximum age 60 so we can eliminate the high risk age groups."

Drug abusers likewise have few special treatment facilities available. The province's single methadone clinic in Edmonton currently has a caseload of only 35 patients. Addiction to street drugs is relatively rare, and so far there has been little need to expand treatment facilities for drug addicts.

But this may soon change. Mr Totten said Alberta officials are keeping a close eye on their western border. If British Columbia's plan to force identified addicts to receive compulsory treatment is enacted, BC addicts could escape the law simply by moving into Alberta. Existing treatment and law enforcement facilities would be inadequate in that event, and the government and AADAC would have to re-adjust their priorities to deal with an unwelcome addition to their abuse problems.

Another area of concern is the increase in drinking problems among the elderly. "In a genuine attempt to be good to old people, we've unwittingly put in place many of the predisposing factors that contribute to this phenomenon," said Mr Totten.

"Alberta is probably one of the better provinces in Canada in which to live once you've reached 65. Government has provided an income insurance plan, free medicare, financial assistance for the purchase of eyeglasses, and several other social assistance programs. But we also take these people out of the work stream and they feel they're no good to anyone anymore. They become lonely and out of touch, and they have the money to use pills and alcohol as their solace."

The amount of alcohol consumed in senior citizens' highrises is startling, says Mr Totten, and nursing homes are becoming increasingly concerned about alcohol abuse by their residents. AADAC is now exploring the possibility of working with some nursing homes in the larger centres to see what role it can play in lessening the problem.

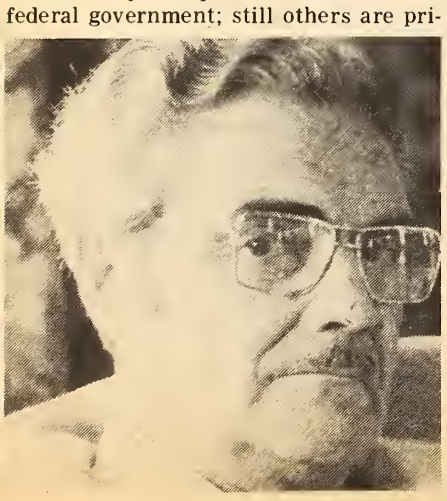
Besides attempting to deal with current dependence problems in the province, Alberta government officials and health personnel are casting a concerned eye into the future. Even if disillusioned utopia searchers do not surface as an additional drain on treatment facilities, simple economic and population growth coupled with the standard per capita alcoholism and drug abuse rate will tax existing alcoholism and drug abuse facilities beyond their limits.

The population expansion in Calgary and Edmonton is mirrored, and in some cases surpassed, in other areas of the province. Fort McMurray, where the oil sands are being developed, had a population of 1,100 a few years ago. Now it's 18,000, and the predictions are that it will reach 30,000. With the development of the petrochemical industry east of Red Deer, that city's population is expected to increase from its current 35,000 to 75,000 by the year 2000.

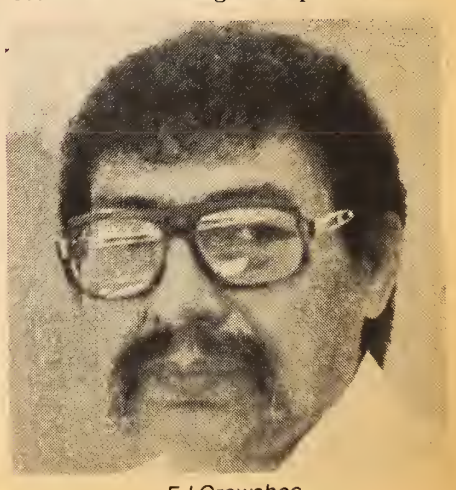
"We know our problems are going to get bigger," said Mr Totten. "We're trying to project what our needs will be, but it's difficult to do on a year-to-year basis."

In the early stages of development, Alberta's alcoholism services bypassed the rural areas in favor of the major centres of Edmonton and Calgary. But according to Mr Totten, the emphasis has shifted.

"This year we've opened new offices in Drumheller and Drayton Valley, and we hope to expand even more into the rural areas. We're trying to serve communities without an office on a one or two-day a week basis. We frequently can't meet the need that exists, and such an approach is both time consuming and expensive."



Wilf Totten



Ed Crowshoe

The Journal

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Secret drug files will be vetted

By Bryne Carruthers

OTTAWA — There's good news for thousands of soft drug users across Canada who have never been convicted of drug crimes but who nevertheless have their names on drug user files compiled over the years by the federal Bureau of Dangerous Drugs.

The Journal, which revealed the existence of the cannabis users list and triggered public concern over the excessive compiling of files by government, has learned the Bureau of Dangerous Drugs has been ordered by senior health department officials to vet the files and remove the names of any individuals who don't have drug conviction records.

In the related and broader public decision, the health department has also decided the initial intent of the files — to keep track of opiate users and to have available data of use to medical professionals interested in treating hard drug users — should be reimposed.

In recent years, with the crackdown on cannabis users, much more widespread than convictions of opiate users, the files on cannabis users now heavily outweigh those on hard drug users.

For example, at the end of 1976, there were 163,279 files on known (but not necessarily convicted) users of marijuana and hashish, including almost 30,000 names added in 1976 alone.

If the convictions are any indication, most of the individuals with files at the Bureau of Dangerous Drugs are simply users of cannabis and other soft drugs, rather than traffickers or importers.

By contrast, the bureau has only 15,264 files on known narcotic or opiate users, with only 500 heroin users' names added in 1976.

The fact the new Human Rights Commission was showing direct interest in the existence of the drug user files and that the government might face a showdown with the commission over access to those files by affected individuals, seems to have played a major role in the health department's quick turn around on the drug user files policy.

The main argument previously used by the Bureau of Dangerous Drugs to rationalize the existence of the user files with the names of individuals — that they were needed to develop statistical trends data on drug use for the United Nations under a treaty — seems to have been discounted within the department.

The feeling now is that even with the individual files, the drug statistics were still inaccurate and drug statistics based solely on conviction statistics (all available publicly) would be just as useful, a lot easier to compile and maintain, and considerably less threatening to human rights.

Coincidentally perhaps, the Bureau of Dangerous Drugs is faced with another bit of bad news. As part of the federal government's decentralization plans, the bureau is to be transferred to North Bay, files and all.

The Journal hasn't yet been able to determine precisely when the files will be vetted completely or what will happen to the old files. The obvious hope of many is that the files will be destroyed, perhaps by government shredders used for many other secrets generated daily by the government in Ottawa.

Thailand gets drug attachés

DETROIT — Six western European nations have posted law enforcement attachés to their embassies in Bangkok in an effort to try and stem the flow of illegal heroin from Thailand.

"They are attempting to work with the Thai government to intercept the traffic before it reaches Europe. This is an extraordinary development in the international field," according to Mathea Falco, US state department senior advisor for international narcotics matters.

Ms Falco told the annual meeting of the Alcohol and Drug Problems Association: "In western Europe there is heroin addiction of a truly startling degree.

"I have just returned from Italy where I heard over and over again how heroin is devastating the cities, and driving the crime rate up. All the same things are being seen as in this country since the late 60s."

Since her appointment last January, "the one message that has become clear from my travels is that drug abuse is no longer a US problem. It is truly international."

The southeast Asia opium producing countries are experiencing addiction on a scale thought impossible five years ago. "Many of the young people who are becoming addicted are sons and daughters of people who lead the country, and there is a great worry about the future leadership," Ms Falco added.

Violence and death in the Sierra Madre region of Mexico, where most of the heroin originates, "makes Washington or Detroit look positively tame."

In South America, the drug traffic threatens the independence of several governments, and the integrity of government officials, she said.

US evaluates therapeutic heroin

By Harvey McConnell

DETROIT — Legal use of heroin to relieve pain for terminal cancer patients is now being investigated by American government agencies.

Peter Bourne, director of the Office of Drug Abuse Prevention, said the National Cancer Institute will take the lead in developing a more objective approach to heroin use on a purely medical basis, "and provide research studies to assess whether heroin, in fact, has any use" in cancer cases.

Already, the National Institute on Drug Abuse is financing a study at the Sloane Kettering cancer institute, Dr Bourne told the Alcohol and Drug Problems Association annual conference here.

He said only recently has consideration been given to whether heroin may be any better than present drugs: the attitude was its use could not be tolerated under any circumstances.

Many other countries, however, "apparently feel it has some merit, and it has a good deal of use and acceptability."

Canada cool
See page 3

The object will be "primarily to treat it not in any emotional way, and tied to the issue of heroin abuse, but to look at it from the purely medical standpoint, and in an objective way."

Dr Bourne said he has asked the department of health, education and welfare to establish a commission to set policy and coordinate programs for using other abused drugs, including marijuana, in a medical context.

Dr Bourne said people should not be prevented "from receiving the benefits which might be derived from the use of these drugs just because they are drugs that have been abused."

Dr Bourne said there is no expectation the government will push for development of a heroin maintenance program for addicts "as we feel it really doesn't have very much to offer.

"However, if somebody feels very strongly that they want to write an experimental program, that proposal would get the same consideration as any other research proposal. It would have to be done under the most stringent controls and guidelines."

(See — US — page 7)

Regular features

Drug abusers need alcoholics' self-help models

DETROIT — The major need in the drug abuse field is for self-help organizations which do not depend on federal funds or professionals to run them.

Robert DuPont, director of the National Institute on Drug Abuse, said a major source for learning how to do this will be the alcoholism field.

"While we have perhaps something to share with the alcoholism field in terms of organization and bureaucratic activities, we have much to learn in terms of citizen input and the nature of the problem," he told the annual meeting of the Alcohol and Drug Problems Association here.

The emphasis on supply reduction and law enforcement "has in some ways prevented us from thinking about some of the more human and personal aspects of the drug abuse experience, and we are going to have to do a lot more thinking about that."

This includes asking why some people are more vulnerable to drug abuse, and looking at the public's ability to respond to the problem of drug dependence.

Dr DuPont pointed out: "It is clear to me drug abusers are not able to identify themselves publicly, and thereby gain the support of their peers in the community, the same way the alcoholics are able to do."

There is a lack of citizen organizations, such as the National Council on Alcoholism or the National Organization of Mental Health, he said.

More than anything else, Dr DuPont said, "I think we need self-help organizations that are not funded by the government at all, programs that are run entirely by, and for, the people who are in need of the services . . . and that don't have professionals of any kind involved.

"This is the ultimate in consumerism, and if we are going to do that, we are going to have to learn from those in the alcoholism field."

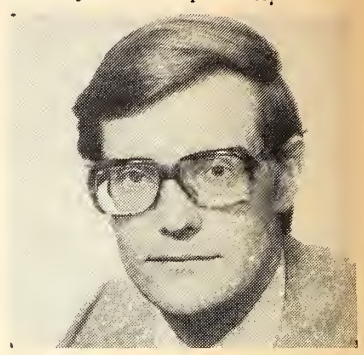
Dr DuPont said a just completed NIDA study, carried out in association with state agencies, shows there are 3,100 treatment units in the United States. Some 77% report they treat drug abusers with alcohol problems, and 37% treat alcoholics with no other drug abuse problem.

"There is a lot of talk about integration of drugs and alcohol programs, and it is quite clear this is very much the order of business in the field now," he said.

Dr DuPont said he felt much more could be done between NIDA and the National Institute on Alcohol Abuse and Alcoholism in the fields of research, primary prevention, and training.

But the question of merging the two institutes is a vexed one. "We might lose vital public support that is essential for the carrying out of our activities."

Dr DuPont said he did not know which would be better: two separate institutes in one agency, as now, or one kind of agency with two separate components.



Robert DuPont

No real idea of numbers

Women drinkers: more specific research vital

By Harvey McConnell

WASHINGTON — No real figures exist for the number of women alcoholics in the United States which makes more social and biomedical research vital, according to Senator William Hathaway.

Senator Hathaway, chairman of the senate sub-committee on alcoholism and narcotics, said estimates reveal 30% to 50% of all alcoholics in the country are women.

"One reason for our lack of information is that for too long the woman with a drinking problem has been ignored, tolerated with amusement, or shut away in a backroom, out of misguided overprotection by her family, her physician, and her society," he declared.

Estimates reveal that in the United States 30% to 50% of all alcoholics are women. The female alcoholic has been protected for too long, according to Senator William Hathaway.

Senator Hathaway told delegates to the national training institute on women and alcoholism, organized here by the National Council on Alcoholism: "I would like to see us study techniques of how to get women into treatment, and evaluate the outcome of the treatment.

(More from the institute page 5)

"The field of alcoholism is one in which cost-benefit studies are needed. We need to know what works, and how much it costs to deliver service to the alcoholic woman, and what we and the patients have truly gained from this effort.

"We must investigate optimum treatment resources for women, and ways in which they can be improved."

During the summer, Senator Hathaway's sub - committee started to investigate the impact of alcohol abuse on the family, the effects of child abuse, desertion, and home accidents.

"We must help the children and spouse of the alcohol abuser. That is, the 'other victims' as well as the drinker."

Investigations are needed into the problems of women who work both full and part time, the older woman who returns to the work force, and the professional woman, he said.

Biomedical research is necessary. "We must determine what alcoholism in women looks like."

Senator Hathaway declared: "Perhaps most important, we need to look at prevention strategies, so that we can reduce the number of women suffering from alcohol abuse and alcoholism, and consequently, reduce the expanding cost to our society."

Senator Edward Kennedy, chairman of the Senate sub-committee on health, said one of the major difficulties is finding funds for alcohol and drug programs.

The explosion in health care costs brought on by technology has had a direct impact on the cost of medical aid schemes. "That puts an enormous squeeze on other direct appropriations' bills."

Senator Kennedy added: "Make no mistake about it, we are searching desperately for scarce resources. This issue is a matter of national priority and national importance in the terms of our society."

ODAP will be phased out from April, 1978

DETROIT — The Office of Drug Abuse Prevention will probably stay in existence until April, 1978, according to director Peter Bourne.

"By then we hope to have completed the studies and activities we are conducting at the present time," Dr Bourne said.

"Most of the staff will continue on the White House payroll, even if ODAP is phased out. We hope to be able to perform the same functions, even if the ODAP label is not there."

Dr Bourne said the studies range from combining the services which manage the Mexican border, such as immigration and drug enforcement, to drug law enforcement, narcotics intelligence, "and the whole issue of demand reduction, treatment, rehabilitation, and prevention that will look across the board at efforts in these areas."

Dr Bourne said there is much talk about consolidation of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. On the managerial and constituency level there is a variety of reasons for not doing so.

However, "one of the strongest reasons in favor of some kind of consolidation is that it would increase the status and clout of the two separate efforts in the federal government, perhaps to the benefit of other audiences."

CC, sour mash suspects spooked out by CIA

By Wayne Howell

ON SEPTEMBER 23, 1977 the CIA released 2,532 pages of heretofore "top secret" documents. These documents revealed that in the mid-1950s the CIA embarked upon a 25 year multi-million dollar covert study of American drinking habits, code-named MK-ULTRA. The alcohol part of MK-ULTRA was known as sub-project 63.

(One can only guess at what the other 62 sub-projects were about — but we know that at least one of them involved giving LSD to unsuspecting army officers, one of whom jumped to his death from a window.)

The details of sub-project 63 are somewhat fragmentary, but as described by UPI staff writer Daniel Gilmore, they involved pocket tape recorders, interviews with bartenders, two-way mirrors, Polaroid camera, plus one fully-equipped bar where unsuspecting customers were taped and photographed in clandestine fashion.

According to Daniel Gilmore, the CIA learned very little from sub-project 63, just as it learned very little from the other mind and behavior control projects that comprised MK-ULTRA.

Not so! I happen to be privy to information which shows the CIA is now in possession of some *very significant highly classified data* relating to the drinking habits of Americans and the effects of alcohol upon them.

According to my informant, some of the more vital information arose out of the operation code-named FOXFIRE.

FOXFIRE evolved from the interviews with bartenders. Rather than believe these men, many of whom could not pass a security clearance and some of whom were known subversives who recommended Scotch and Canadian whiskies over patriotic Kentucky bourbon, the CIA disguised one of its own spooks (an operative named Howard Hunt) in a red wig. Using this cover, he posed as an ordinary bartender and was able to extract heretofore unknown information from the unsuspecting clients. The results? Operation FOXFIRE revealed that most men at bars say they drink because their wives don't understand them.

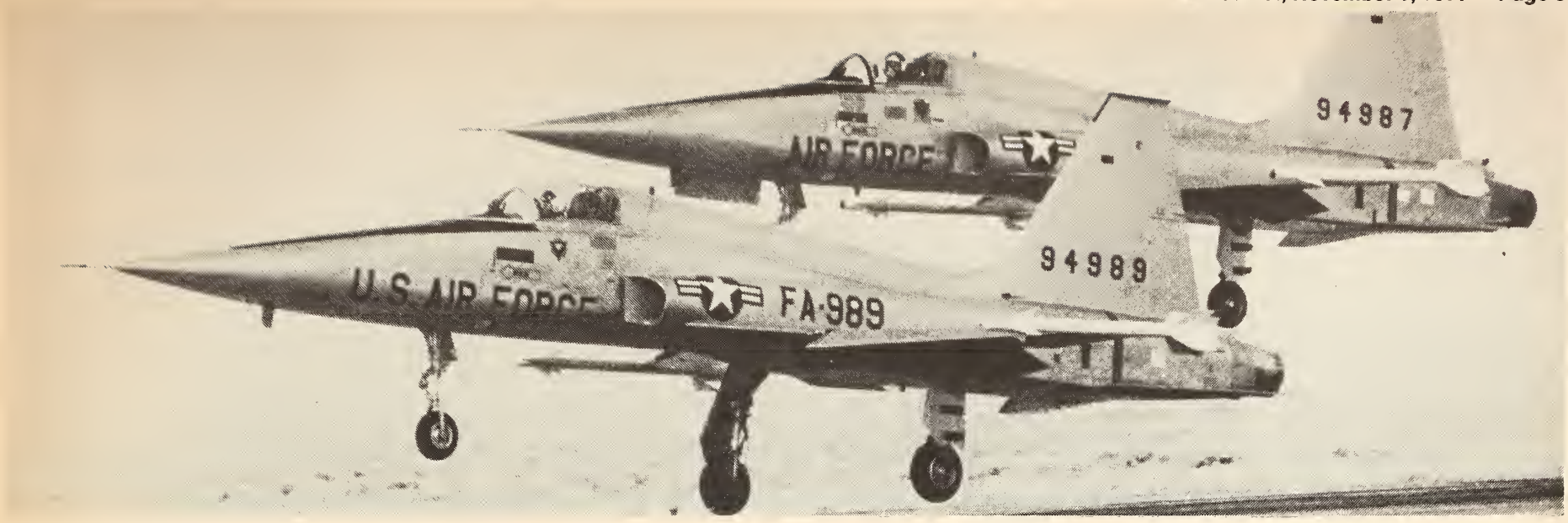
Project SAILOR arose out of the bar-bugging operation. Through appropriately placed contacts, the CIA arranged to have multi-millionaire industrialist Howard Hughes construct a special research cruise ship called the GO-BAR Explorer. Sailing out of Miami, the GO-BAR Explorer cruised the Caribbean with a full complement of unsuspecting American tourists. The results of this experiment are contained in a top secret file entitled SHIPBOARD ROMANCE. My informant was unable to procure this file but he has it on good authority that the CIA cameras recorded not only increased drinking activity, but increased sexual activity as well.

Project BAG-JOB apparently entailed covert entries into the offices of the psychiatrists of known drinkers. Initial operations provided information showing that drinkers did not always tell their doctors the true extent of their drinking. More worthwhile information undoubtedly would have been obtained had BAG-JOB continued but, unfortunately, the project had to be terminated when a BAG-JOB entry became an issue in a drinker's divorce case. Attempts to influence the judge with a proposed appointment to the Supreme Court were unsuccessful.

Even more vital information was gleaned as a result of project VOID. A special spook-unit known as 'the plumbers' was detailed to stake out the mens' washrooms in drinking establishments.

Ingeniously disguised as wash-stands and prophylactic dispensers, the plumbers surreptitiously observed drinkers in flagrant acts of micturition. Their preliminary findings indicated alcohol has mild diuretic properties. Unfortunately, project VOID had to be prematurely terminated when a washroom attendant found a tape on one of the toilet-cubicle doors and called the municipal police who placed the entire crew of plumbers under arrest. The whole episode was covered up in the interests of national security.

(Wayne Howell is an Ottawa physician and freelance writer).



Alcohol program successes in US forces

Rehabilitation saves air force $14m yearly

DETROIT — A majority of United States Air Force personnel affected by alcoholism have been restored to effective duty after treatment.

This is one of the major findings of a study which used advanced air force computer technology to assess what happened to alcohol abusers who underwent treatment from 1971 through 1975.

Captain John Killeen, alcohol abuse program monitor, said the study showed "some of our most highly trained and experienced people are affected by alcoholism."

However, a majority were restored to effective duty "and their post treatment performance improved on nearly every variable evaluated."

The treatment program, which has been in operation since 1971, has also saved the air force a lot of money, Captain Killeen said in a report to the annual meeting of the Alcohol and Drug Problems Association meeting here.

He explained: "The assumption was made that due to the severity of their alcohol problems, all of these members would have been lost to the air force if they had not been entered into rehabilitation.

"Present value of replacement costs would be $21.1 million. The present value of treatment cost is $6.7 million."

Only in one area did the study not succeed. In evaluating the performance of 1,992 personnel who completed treatment, a random sample of personnel for each year was selected as control.

Captain Killeen explained that while sex, race, and marital status of the alcohol abusers were comparable to the control group, "their military grade level, time in service, educational level, and skill level were higher."

By Harvey McConnnell

This meant most subsequent comparisons were weakened because of these significant differences. "Essentially, the control reflected the air force average."

Only 11.5% of those who received treatment were discharged eventually, and only 4% received less than honorable discharges. At the end of the study, it was found some 53% of those who received treatment were still on active duty.

Those who received treatment were again eligible for promotion, and their performance and conduct improved to the point their promotion eligibility was equal to, or higher, than controls.

Captain Killeen said the study was also an experiment, using the air force's computer network, called the advanced personnel data system. It links every major air force installation with major command headquarters, and with the central personnel centre.

"We have used the system to improve program management, to reduce costly manual reporting, and to do this long-term research on the effectiveness of our programs."

Pilots seem to be the one group in the air force where alcohol problems are minimal. The examinations just to stay on flying status are so stringent "any alcohol problem would surface rapidly," Captain Killeen commented.

Spotting a person with a drinking problem is hampered in the air force, as in the other US services, by a shortage of doctors.

This means there can be no large scale training programs in alcohol abuse, and outside medical specialists are hired to fly to various bases and give training on the spot.

Captain Killeen said in all cases where the doctor suspects a person has an alcohol problem he reports his suspicion to his commanding officer. It is up to the commanding officer to order trained drug and alcohol counsellors to contact the individual.

More from the ADPA next month

Pentagon's drug fears subside

DETROIT — The explosion of heroin use in western Europe has so far not affected United States Air Force personnel as much as Pentagon officials thought possible.

Captain John Killeen, USAF alcohol abuse program monitor, said: "We have been surprised people are not doing as much as might be expected with the drug scene taking off in Europe. Overall, hard drug use has declined dramatically in the air force since 1972."

The only real problem with drug abuse is, in fact, in Europe, but drugs concerned are generally amphetamines and Mandrax. That is on a small scale "because we have been doing some tough urine test programs over there," Capt Killeen added.

He said the air force has always had the lowest rate of abuse of any of the American services. One reason is there is always a waiting list of recruits "and we can choose more selectively."

Alcohol problems cost US Navy up to $680m

WASHINGTON — Rehabilitating American sailors and marines who are alcoholic not only saves money but increases awareness in the two services that the problem can be arrested.

These are among the major findings of a cost-benefit study of the US Navy's alcoholism rehabilitation programs. Alcohol abuse among the 720,000 members results in an economic loss to the navy of $360-$680 million a year.

The study found that if alcoholics are given the minimum treatment required by law, arbitrarily discharged, and turned over to the Veterans Administration, the cost of their replacement would be 2.2 times higher than the present alcoholism rehabilitation effort.

The Navy operates three large alcohol rehabilitation centres, 15 smaller alcohol rehabilitation units in designated naval medical centres, and 56 alcohol rehabilitation drydocks in selected local commands.

During 1976, some 5,077 alcoholics were treated in residential facilities and 12,609 treated on an outpatient basis.

The cost of residential rehabilitation during the same period was $22.6 million. The report said it would cost $49 million to obtain the same number of man years of future service by recruiting and training to replace the personnel.

On an individual level, the savings in successful rehabilitation can be high. Rehabilitating a pilot, for example, could save from $65,000 to $400,000, depending on cost of undergraduate pilot training and the type of aircraft he flies.

One of the most striking results of the rehabilitation programs has been found in a two year post evaluation study of former alcoholics.

Treatment has proved 83% effective in rehabilitating alcoholics who are 26 years old and more. Most of these are career personnel.

In those under 26 years, the rehabilitation program has been effective in only 44% of the personnel.

Before receiving treatment, alcoholics had a sick day rate of three times the average for all naval personnel. Successful rehabilitation reduced that figure to the norm.

An examination of the medical histories of 538 sailors found before treatment 20% suffered from personal injuries at a rate six times the average for the service. The remaining 80% had an accident rate twice as high as the average.

The report pointed out some 30% of alcoholics had no service history of any form of hospital treatment. It added that, for this reason, medical officers and their staff cannot be expected to be the sole means of identifying alcohol dependent people needing treatment.

A sampling of commanding officers showed some 33% of the punishment cases brought before them, such as unauthorized absence or conduct unbecoming, involved alcohol abuse.

Smoking ban rejected

WASHINGTON — A petition to ban smoking by US airline pilots and flight crews has been turned down by the Federal Aviation Authority.

A number of consumer groups submitted a petition a year ago which claimed smoking "has a deleterious effect on vital brain and nervous system functions that are incompatible with maximum air safety."

The FAA in its turndown said any evidence smoking impairs performance "is too inconclusive."

The petition wanted a ban on smoking in the cockpit, and a rule flight crews were not to smoke for at least eight hours prior to takeoff.

Canada's cool to therapeutic heroin

TORONTO — There appears to be little enthusiasm in Canada for use of heroin as a pain-reliever in terminally ill patients.

Ian Henderson of the Non-Medical Use of Drugs Directorate told The Journal: "No one is pushing to have heroin used in Canada. However, it is a good analgesic, and has been used in the UK for many terminal pain problems."

Dr Henderson said a version of the Brompton mixture, named after a British hospital, is being used now in Canadian hospitals as an analgesic for chronically ill patients. In Britain, he said, a Brompton mixture contains heroin and cocaine. However, because it is illegal to import heroin into Canada, hospitals here can use drugs such as morphine, methadone, or laudanum in combination with cocaine to obtain similar pain relief for patients.

The Royal Victoria Hospital in Montreal, Quebec, for example, is using a Brompton mixture which contains a varying amount of morphine, 10 mg of cocaine, 2.5 ml of ethyl alcohol (98%), 1 ml of flavoring syrup, and a variable amount of chloroform water for a total of 20 ml oral dose. The mixture is being administered to patients in the Palliative Care Unit of the hospital and in other departments as well, Dottie Wilson, administrative assistant of the PCU told The Journal.

"There is no reason for cancer patients to be in pain," she said. Mrs Wilson believes Brompton mixture is in use in many hospitals in both Canada and the United States: "I hope all hospitals are using it."

An interesting sidelight, pointed out by Dr Lionel Solursh, associate head of psychiatry at Toronto's Western Hospital, is that under the Narcotic Control Act heroin may be prescribed to a patient by a physician. The catch? It's illegal to import heroin.

Betty Lou Lee reports from
a conference on Women and Smoking
Toronto, Ontario

Smokers on the pill warned of cardiac dangers

WOMEN WHO use both cigarettes and the birth control pill have a greatly increased risk of heart attack and Health and Welfare Canada is taking steps to see that they are warned of this hazard.

It is going to require pill manufacturers to include a reminder about the interacting effects in information given to doctors, and in information given to users.

Harold Coburn, special adviser to the Non-Medical Use of Drugs Directorate, outlined some of the department's expanded program on smoking and health.

The original program in 1964 was aimed at informing the public of the health risks, getting smokers to stop, and dissuading non-smokers from starting. While the hazards are now well-known, "there has been less success than we might have expected in the other two objectives."

While there has been a reduction in the percentage of males who smoke, and a levelling off of the female rates, the number of smokers has climbed from 5.5 million in 1965 to 6.3 million in 1975.

"The potential suffering and disability attributable to smoking may have increased rather than decreased."

Two more aims have been added to the department's program: helping those who want to protect themselves from second-hand smoke, and reducing the hazards for those who continue to smoke.

Since the dose-response relationship between smoking and all its health effects is well demonstrated, he said, any way that reduces the amount of smoke taken into the body can be expected to reduce the hazards.

The department is encouraging manufacturers to market cigarettes with less tar, nicotine, carbon monoxide, and other constituents, and is cooperating with the agriculture department to try and produce a tobacco that can be used in these cigarettes.

Dr Coburn said there is controversy about "safer cigarettes" because some people believe their benefits have not been demonstrated, and smokers will believe they are safe.

"Although some have made optimistic predictions that moderate use of newer low tar cigarettes may result in low risks, approaching those of non-smokers, in our view it would be premature and misleading to create the impression that some kinds of cigarettes are safe ..... So far as we know, the only safe cigarette is the one you don't light."

Dr Coburn said a recent report by the International Union Against Cancer illustrates the importance of postponing the age at which one starts to smoke, if one is determined to start. Doubling the duration of smoking from 10 to 20 years increases the incidence of lung cancer 16 times, but doubling the number of cigarettes smoked per day only doubles the incidence.

"Part of the continuing increase in lung cancer despite reductions in smoking may be explained by an earlier average age of starting to smoke," Dr Coburn said. Lung cancer has now moved into the top 10 killers of women; it is fourth for those 55 to 59, and fifth for those 50 to 54.

He suggested six ways in which women might be helped to avoid or discontinue smoking, including a follow-up system such as Alcoholics Anonymous has. "There would appear to be a major role for volunteers here to provide group support, buddy systems, and so forth."

Family-centered efforts beginning before or during pregnancy; a special educational program involving doctors, nurses, and birth control clinics; self-help groups among women at work, university, and high schools; and a general approach concerning the use of any drugs, including alcohol and tobacco, during pregnancy, were other possibilities.

Special efforts should also be made to identify women at particular risk for the effects of smoking, such as those on the birth control pill, and those with elevated serum cholesterol or blood pressure.

British find more problems

TWO NEW British studies confirm a greater risk of death from circulatory disease among women who both smoke and use oral contraceptives.

One survey of 46,000 women was conducted by the Royal College of General Practitioners and the other of 17,000 women was done by Professor Martin Vessey of Oxford University's College of Obstetricians and Gynecologists. Both concluded the risk was greater among women over 35 years if they smoke or if they have been on the pill for more than five years.

The presidents of both institutions have issued a statement strongly urging women over 35 years to reconsider the use of oral contraceptives and suggesting that women smokers over 35 who have taken the pill for five years, might reduce their risk by quitting cigarettes.

Both studies were published in *The Lancet*, Oct. 7.

500 neonate deaths yearly

FIVE HUNDRED or more Canadian babies die every year because their mothers smoke during pregnancy, "and death is only the tip of the iceberg" Robert Langford said.

He said a recent British study has shown that 1,500 babies a year die there because of maternal smoking, and the United States estimate is 4,600 annually. A Pennsylvania study of 60,000 pregnant women last year showed a pack-a-day smoker had four times the risk of abruptio placenta during her pregnancy, and that maternal smoking was the second leading cause of infant death.

Dr Langford is past president of the Ontario Interagency Council on Smoking and Health, one of the sponsors of the meeting which he moderated. The other sponsors were the Canadian Council on Smoking and Health, and the Non-Medical Use of Drugs Directorate of Health and Welfare Canada.

Jacqueline Fabia, national health scientist and associate professor of social and preventive medicine at Laval University, presented data from a number of studies in which she has been involved on perinatal mortality.

Sixteen per cent of placental complications and antepartum hemorrhage can be attributed to smoking during pregnancy, one-third of low birth-weight babies are linked to smoking, 14% of prematurity, and 10.5% of perinatal mortality.

The risk to a specific baby varies with other factors, Dr Fabia said: if the mother is very young, older, or of low socio-economic status, the risk can increase considerably.

"If she stops in the first month, the risk of bleeding complications, low birth weight, and perinatal mortality is the same as for a non-smoker.

"But prenatal courses, if they do give cigarette information, often do it at four to five months, which is very late, and it's often given by nurses who are chain smoking."

She had a hard word for some doctors, too, who don't discourage smoking in the pregnant woman. "They say if the mother smokes the baby will be smaller and delivery easier."

Dr Fabia said 43% of women smoke during pregnancy, and the rate is 60% for those under 20. "If they have already had a baby with no problems, they won't believe you about the risks, and they go on smoking."

The hazards do not end with birth. An Israeli study shows an increased risk of hospital admission for bronchitis and pneumonia among children of smokers. In France, the chance of a child having his tonsils and adenoids removed is 28% if neither parent smokes, and 58% if both parents smoke more than 10 cigarettes a day.

Children of smoking mothers have a four-month difference in reading ability at 11 years of age compared to children of non-smokers, and are one centimeter shorter in height. The risk they will also become smokers is high. "Are they already intoxicated and addicts because they live in cigarette smoke? We don't know."

Menopause, metabolism are affected

WOMEN MAY be excused if they feel paranoid about cigarettes: the dreaded weeds are out to get them.

In addition to posing a risk to the fetus during their pregnancies, and putting them at a six-fold risk of heart attack when combined with the birth control pill, cigarettes have now been found to cause an earlier menopause.

Hershel Jick, director of the Boston Collaborative Drug Surveillance Program, which has kept detailed information on 60,000 hospitalized patients for 11 years, reported results of his menopause data to the conference.

Among women 48 and 49 years of age, only 26 % of those who had never smoked were post-menopausal, as compared to 33% of those who were half-a-pack -a-day smokers, and 46% of those who smoked one to two packs.

As in all other diseases associated with smoking, there is a dose-response relationship, Dr Jick said.

He has also found smoking can effect the efficacy of many drugs, because they are metabolized more rapidly. Darvon, for example, is ineffective in 10% of non-smokers, and 20% of heavy smokers in its usually prescribed dose.

Dr Jick said there was no doubt heart attack in young women was a disease of smokers, although tobacco appears to have little to do with cerebral-vascular disease.

Of the 55 women in the program under 46 years who had heart attacks, only three had never smoked. Forty women under 50 had lung cancer "an astromomical number for our data base", and only six had never smoked. One three-pack-a-day smoker who had started at 10 years of age had lung cancer at age 25.

Nationwide survey discloses:

Prenatal classes steer round risks

POSSIBLE DANGERS to the fetus from maternal smoking are undiscussed in almost 20% of the prenatal classes in Canada.

The reasons given for this omission include a lack of time to add additional material to the program, a lack of information or material to give to the women, and instructors who are smoking nurses and reluctant to discuss the subject.

Some agencies do not discuss smoking because they fear psychological harm if mothers do not stop and later have a baby with birth defects or other health problems. Some said the women don't want such information.

An Ottawa team surveyed 353 agencies or organizations giving prenatal classes to 110,000 women in all parts of Canada. The study group included Agnes T. H. Choi-Lao, assistant professor at the University of Ottawa School of Nursing; Dr Brad McRae of Carleton University psychology department; Diana Hayes, a student at St Patrick's College; and Susan Larante, a student at the University of Ottawa School of Nursing. Their information was collected this summer.

Of the classes that do deal with smoking, 69% mention it informally. There are talks by professionals in 30% of classes, and in 20% there is individual counselling by professionals. Almost two-thirds use printed materials, but only 23% give information on how to stop smoking.

In about half the classes, women are asked to stop smoking completely, a quarter ask women to stop smoking during the last six months of pregnancy, and about half advise against smoking in front of infants or children.

Only 21% of respondents felt prepared to give smoking education, but 99% said they would like to have and use material on smoking and pregnancy if it were available.

The study group recommended that a coordinating agency be set up that could make information and material available to such agencies, and that it include the physiological effects of smoking during pregnancy, the importance of stopping or cutting down on cigarettes while pregnant, suggestions on how to stop or cut down, the effects of parental smoking on the health of infants and young children, and information on the use of drugs , including tobacco, during pregnancy.

Training programs on smoking education should be given health professionals who conduct prenatal classes. Fathers and other family members should be included so they can encourage the pregnant woman to stop smoking, and printed materials should be available in the mother's native language.

A resolution passed at the conclusion of the meeting called for more action to warn women of the possible effects of smoking during pregnancy; prematurity, underweight babies, and fetal deaths.

Federal and provincial health ministers will be urged to request doctors to tell all pregnant women of these hazards. Health departments and voluntary agencies will be asked to make literature available.

Prevention program tailored for native people

By Linda Matchan

WINNIPEG — When the ravaged bodies of two young girls from the northern Manitoba Indian reserve of Berens River were retrieved from the dense Manitoba bush last spring, gasoline sniffing was blamed for their disappearance.

Shortly after, the Alcoholism Foundation of Manitoba (AFM) was asked by the community to combat the growing sniffing problem at the reserve, and prevent more tragedies. They've just designed a program they think is going to work.

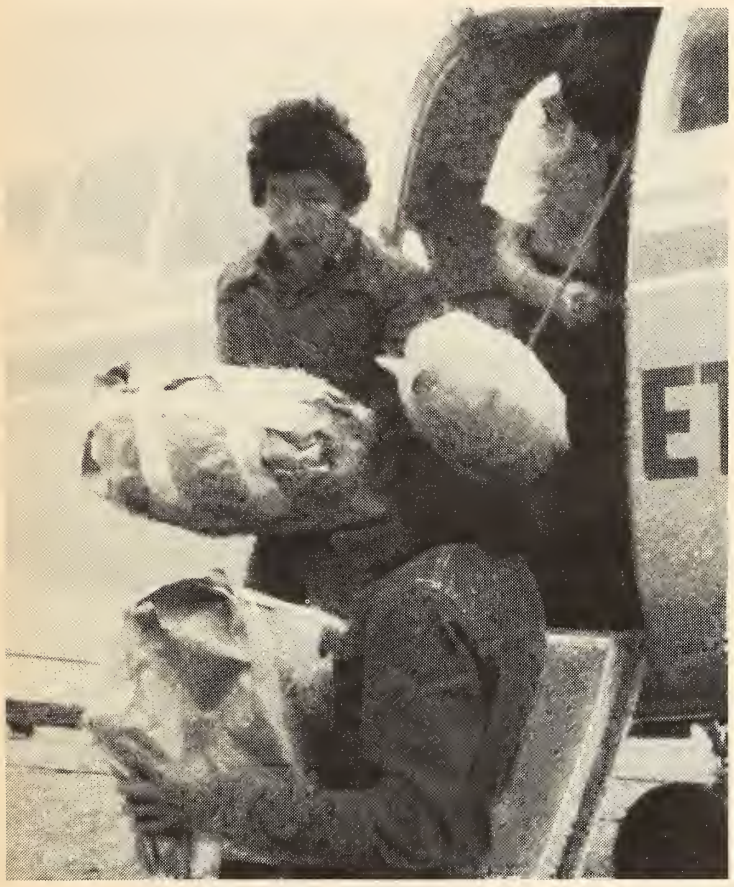
Gasoline and glue sniffing have escalated in the past four years in Berens River from a habit practised by only a handful of chronic sniffers to something that just about every one of the 350 school children in the remote community has tried.

"I've had glue stolen right out of my classroom," recalls Valerie Paape, who was a teacher in Berens River last year and worked on the so-called community oriented prevention program.

Pat Koperno, a prevention development officer with the AFM who helped design the program, describes it as a new approach in prevention education — one tailor-made for native people in northern communities.

Most of the prevention programs that have had some success, such as peer counselling, were unsuited to northern communities like Berens River, says Ms Paape: Berens River is an isolated community of 1,000 Treaty Indians and Métis people, 150 air miles from the nearest urban community, and accessible only by plane and winter road.

But peer counselling, which requires adults to act as counsellors, and older students trained in listening and self-awareness skills, "was too ambitious . . . These resources don't exist in the north," Ms Paape says.



Unloading supplies at Berens River Airport. Photo: Bob Richard

The new prevention program is intended to decrease sniffing by increasing the children's feelings of self-worth, self-confidence, and responsibility, and by providing learning situations directly related to their environment, she says.

"The kids are failing in school because the school system is structured for failure. . . . Their first language is probably not English but nevertheless they are expected to use the standard curriculum work in English. And the work is not valued by the children's families because it's not relevant to their situation."

These children, she says, are "psychologically withdrawn" from school. Though they may attend school regularly they automatically shut off everything their non-native teacher says because he or she is often totally remote from the community's concerns.

A significant number come from homes lacking in attention, love, and care, she said. Many adults in the community are heavy drinkers.

"If these kids are failing in school and they have a rough home life they develop a negative self-concept so they turn to sniffing."

The AFM believes sniffing is also related to the fact there are few young adult models in Berens River for the children to emulate. Because the community's school does not include grades 10 to 12, older children must leave the community to complete their education.

They have no one to look up to or to pattern their behavior after, so they mimic their gasoline-sniffing peers, Ms Koperno says.

The AFM describes the project as a work experience program integrated with academic work. The concept is simple — children are placed in a work situation instead of in a classroom. They are expected to continue with their academic studies, but assignments are tied in to their daily jobs.

"We were aiming for a curriculum that was relevant and meaningful to the kids," said Ms Koperno. "We're still teaching reading, writing, and arithmetic, but we thought we could do it in a way that is related to the work and jobs in the community."

'If kids are failing in school and have a rough home life they develop a negative self-concept so they turn to sniffing . . .'

The program began with a two-week trial run last February, with children in grade eight. Eight students spent the school day at a business or service other than the school, such as the Berens River airport, nursing station, or Hudson's Bay store, and six students remained in the school to work as assistant teachers in the lower grades. They were required to submit application forms for the jobs before they were hired.

The students were asked to keep a daily log of activities and then were evaluated by their "on the job" supervisors. They were expected to complete "workbooks" related to the area of work that stressed the standard grade eight academic skills.

Students working in the store, for example, were required to complete a monthly bookkeeping sheet showing the total expenses of the business. All basic business skills were taught — percentages, accounting, payrolls, mark-up. To answer many of the questions, the students were required to interview members of the community.

"Every third activity is 'doing' things, not just deskwork," says Ms Koperno.

The program was run again in May for four weeks and will operate for the entire 1977-78 school year. It has been expanded to include grade nine and students will participate in three different work experiences.

The results have been impressive, says Ms Koperno. "The response to the program from the community has been tremendous. They have been very supportive and encouraging." Two of the children, one with a history of gasoline-sniffing, were offered part-time jobs for the summer.

Says Ms Paape: "Most kids excelled in their academic work . . . Some said they hoped they'd be able to do it again. To me that says an awful lot."

But what does it have to do with gasoline sniffing?

The AFM hopes it will reduce sniffing by providing relevant learning situations and reducing the phenomenon of psychological withdrawal; by providing positive adult models in the community; and by increasing self-confidence and self-esteem in students in the program.

While the AFM believes it is too soon fully to evaluate the effect of the program, preliminary results "look encouraging," says Gordon Barnes, a research consultant for the regional office of the Non-medical Use of Drugs Directorate, who conducted a survey of the students in Berens River.

'The children are psychologically withdrawn from school . . .'

Most students believed sniffing had decreased since the program started, he says. Of the 30 students in grades seven and nine, 10 said they had been sniffing in the last six months. None of the 12 in grade eight — the children who participated — said they had been sniffing in the last six months.

There are no data yet on grade eight children before the program began — "but at least they haven't started sniffing in the last six months during the program," says Dr Barnes.

"This looks encouraging and I think the program is a really good idea. It's a hopeful type of approach."

Women drinkers are only reached by women

DETROIT — Most working women who have a drinking problem can only be reached effectively by a woman counsellor within an occupational program, in the experience of Dale Masi, of Boston College.

Ms Masi, who acts as advisor to a number of firms, said her experience with the New England Telephone Company taught her much.

"The company has had an industrial alcohol program for 10 years, and it has been staffed by three men who have really done a good job. The medical director asked us to come in because they did not seem to be reaching two groups — management and women.

"All I had to do was put a woman graduate student in the office and women started coming."

Most occupational programs have been designed and administered by men for a predominantly male caseload. Now, a number of companies are concerned about their women employees.

Ms Masi said: "They are running around trying to get one woman who then becomes the token counsellor. That won't do."

Women often want their own self-help group where they can share their problems with other women.

Ms Masi added: "We have found supervisors need to be helped in order to confront women. Feminism is making itself felt in the work place, and particular problems are hitting women because of this."

Prevention programs for women are also necessary.

Ms Masi explained: "Women are now in a very competitive position with men, and the stress of this is something that needs attention.

"Women need to talk about this. What happens to a lot of men when they come under stress is they turn to alcohol. We hope in a preventive manner not to have women follow the same pattern.

"Women also need help in the work place on how to deal with men on a non-sexist basis."

Using the model system developed for men will not work necessarily for women. Absenteeism, for example, is no guide to a possible problem because women already have a higher absentee rate than men, mainly because of responsibilities with their children, she said.

Almost all occupational program consultants in the US are men. This has to change, Ms Masi added.

"We have to be ready to work as hard as the male executives work. Women are going to have to occupy critical positions in the system if we are ever going to effect changes for women alcoholics."

Fingerprint for FAS

NEW YORK — Study of the fingerprints of children may serve as a useful marker in the fetal alcohol syndrome, according to recent study.

The idea is based on the phenomenon that exposure of the fetus to deleterious agents during the period of formation of epidermal patterns may result in abnormal dermatoglyphics, says Qutub H. Qazi, a pediatrician at the State University of New York, Downstate Medical Center, Brooklyn.

Dr Qazi tested the validity of the idea in 13 female unrelated black children and found a significant difference between them and 100 black female controls.

In all cases the diagnosis was based on characteristic clinical signs and history of maternal heavy drinking during pregnancy.

Significant differences in dermatoglyphics were found in the following areas: a) patients had a lower frequency of whorls and a higher frequency of ulnar and radial loops; and b) they also had a higher a-b ridge count.

But no significant differences were found in other parameters studied.

"Because of the relatively small number of patients in the study, it is impossible to be definitive about the observed differences," Dr Qazi told **The Journal.**

"But if these observations can be confirmed in a larger sample of patients, dermatoglyphics may serve as a useful marker in this syndrome."

Women's world forum

WASHINGTON — A first step is being made to develop an international forum for women which will deal with problems of alcoholism and drug abuse.

A survey now being carried out in a number of countries will lead, it is hoped, to a forum next June in Zurich at the meeting of the International Council on Alcohol and Addictions.

Antonia D'Angelo, head of the National Council on Alcoholism's committee on women and alcoholism, is chairman of the organizing committee.

She explained: "We feel the visibility of women is greater than it has ever been, and this should be harnessed in some way internationally.

"The purpose is not just an exchange of information, although this is necessary. What we really want to do is set up some kind of international women's group so we can really come together on many issues."

It is obvious that for women in many countries "we are not at the same place at the same time," but all of them want change.

At the Zurich meeting, "we want to set goals and develop strategy as to how we can help other women. After all, if people are not involved, governments will not move," Ms D'Angelo said.

Following Supreme Court ruling

Police find way round breath test mixup

OTTAWA — Canada's Supreme Court has thrown the country's breath test law enforcement into confusion with a ruling that at least two breath samples are required for conviction for drinking-driving offences under the Criminal Code.

The police forces have already said they have a way around the court decision. If only one breath sample has been taken, the individual can be charged with the old crime of impaired driving, which requires evidence in court that the person was obviously impaired while at the wheel of a motor vehicle.

Ironically, the breath test legislation was originally introduced under the Criminal Code to make drinking-driving convictions more scientific than the old "walk a straight line" approach, by relying on a machine which through breath samples can measure the level of alcohol in one's blood.

The trigger level for convictions was set at the equivalent of 80 milligrams of alcohol per hundred millilitres of blood.

The Supreme Court challenge related to a case in New Brunswick involving Joseph Noble, arrested and charged by police on May 22, 1976, for driving with an excessive blood alcohol level, based on only one breath sample.

Mr Noble was acquitted first by Fredericton Judge James Harper who ruled that 1975 Criminal Code amendments required police to take two or more breath samples instead of the traditional single sample.

New Brunswick appealed but the province's appeal court supported the lower court's interpretation, as did the Supreme Court of Canada most recently.

In the meantime, the publicity surrounding the case put in limbo some 400 similar cases in New Brunswick and probably hundreds elsewhere.

Police in some regions switched quickly to the taking of two samples, others merely switched to impaired driving charges.

The RCMP, which takes care of policing in most provinces and in many municipalities, is generally continuing to use only one breath sample. The force's lawyers plan to study the implications of the Supreme Court decision before deciding whether automatically to start taking two breath samples.

Women drug abusers have more ills

By Harvey McConnell

DETROIT — Women drug abusers had significantly more medical problems than male counterparts, a study of 10 treatment programs in four areas of the United States has found.

Overall, only 10% of the 140 women and 65 men had no medical abnormalities on admission, and of these, 6% developed abnormalities during the course of treatment.

Marcia Andersen, of the Women's Drug Research Project, told the annual meeting of the Alcohol and Drug Problems Association here that women had more problems than men in 11 out of 16 classifications.

The most significant differences involved heart, genital, neurological, lymph nodes, and nose problems. Men had significantly more mental problems.

Among women, 56% had at least one gynecological problem on admission, and 40% of this group needed immediate attention. "In view of this finding, a gynecological examination needs to be made routine for all initial physical examinations," Ms Andersen said.

In the study, a random selection of medical records was made from each of the 10 treatment centres. The client population was 51% black, 40% white, 8% Hispanic, and 1% Asian.

"Looking at all the problems found on initial examination, plus those that developed during treatment, women had significantly higher rate of endocrine, metabolic, respiratory, and urinary system problems," Ms Andersen declared.

One interesting finding among the women was that those who had clean urines during the course of treatment displayed more medical problems in certain categories than women who continued to take drugs.

Ms Andersen offered possible explanations: "It may be that the restabilization of the body after drug use is more complicated for women due to their complex hormonal system.

"Secondly, it has been documented in the literature that life changes for women, such as marriage or giving birth, produce changes that account for variances in numerous illnesses."

Among the women, 29% had supported their drug habit in part by prostitution. They had a higher rate of circulatory, neurological, and urinary problems than the other women in the study.

Dr Ernest Noble's candid assessment

Tight funding behind most NIAAA criticism

DETROIT — Strictures on funding are the principal cause of friction between many in the alcoholism field and the National Institute on Alcohol Abuse and Alcoholism.

This is the candid assessment NIAAA director Ernest Noble presented at the annual meeting here of the Alcohol and Drug Problems Association. He had spoken earlier to a number of angry state program directors.

Dr Noble said: "I am aware of certain dissatisfactions, at times bordering on hostility, that are frequently being expressed concerning NIAAA, and its posture on, and reaction to, a variety of issues."

He is aware that on the surface he and his staff "appear to lack sensitivity to many of the needs being expressed by the field; that we appear to be rigid, even unfeeling, in our response to these needs."

At the same time, he said, both sides "have become increasingly frustrated with our inability to meet the many funding needs that are so vital to us both. My judgment is that much of your reaction, and perhaps part of ours, is based mostly on this dissatisfaction."

Despite the rift, the two sides must work closely towards a common goal: to treat the suffering alcoholic population.

"This goal will never be obtained if we let frustration and emotionalism overcome our common sense and good will." Dr Noble said there needs to be an end to the distracting debate over a national strategy: whether alcohol should become less available, or attempts be made to change the way people use alcohol.

He said: "The policy I favor, and the one I am pursuing as director synthesizes both strategies, and adds a third: building on our base of knowledge. This is why we need to do research in our strategy."

He said by 1983 he wanted to see 60% of the health care costs for alcoholism treatment coming from third party payments. At the same time, half of the insured population should have broadly based coverage for alcoholism services.

By the same year, much can be done to increase the number of counselling services, and there should be alcoholism programs to cover at least half the working force.

At present, NIAAA is studying the marketing and advertising strategy of the beverage industry, which will help in future action.

He said there should be studies of the effect on price and consumption, as well as a review of state alcohol beverage controls laws relating to points such as hours of opening, and legal drinking age.

Speed and barbs UK's major problem

By Thomas Land

LONDON — The simultaneous misuse of several drugs, such as amphetamines and barbiturates, may have grown into a greater social problem in Britain than heroin addiction, according to an authoritative specialist report.

But the essential provision of general psychiatric services and treatment clinics for the young multiple drug misusers, is "largely lacking", the report adds.

The Interim Report of the Treatment and Rehabilitation Working Group of the Advisory Council on the Misuse of Drugs* has been published by the department of health and social security here. It has provoked much concerned public comment — perhaps because of its publication shortly after the death of a British cabinet minister's son from an overdose of morphine.

Yet the report contains sufficient cause for concern, even without its tragic timing. For it concludes that although multiple drug misuse may well have become the nation's major drug problem of the decade, services for overdosed patients are frequently overburdened and inadequate.

Clinics in the capital are more heavily loaded than ever before, the authors of the report say, and some young people have difficulty in finding appropriate treatment rapidly. Indeed, it can be difficult for those who wish to stop using drugs to find suitable facilities and there is a lack of choice in rehabilitation facilities.

The working group was established in 1975 to undertake a comprehensive review of the treatment and rehabilitation services for the misusers of drugs, and to make recommendations for dealing with practical problems.

Its interim report amounts to a dramatic plea for attention and money to be directed to the overburdened social services. And its plea was promptly echoed by some of Britain's most influential opinion makers.

Thus the weekly London *Economist* comments editorially that, "in the present era of cash limits and the reallocation of health service resources from London to the provinces, any expansion of services for these drug abusers has a poor chance. Nor do they attract so much sympathy, either from the public or from health service workers, as the straightforward heroin addict, who stands to be regarded as more sinned against than sinning. Perhaps those who control the purse strings should reflect on the huge amounts of resources that are devoted to caring for the consequences of the most widely abused addictive drugs of all — nicotine and alcohol."

The working group, chaired by a Labour member of parliament, accepts what used to be an unfashionable view, that the existence of authorized sources of narcotics supply does not prevent the growth of a criminal black market. Indeed, the report is critical of how the much-vaunted British system of treating addiction is working in practice.

The official theory a decade ago was that, by encouraging addicts to go to special clinics, and by restricting the power of doctors to prescribe, heroin addiction could be at least contained. But the working group now concludes treatment is having little success and, unless the new multiple drug abusers are consumers of opiates, they may well be turned away by the clinics which administer the official anti-addiction program.

Aware of Britain's cool, current financial climate, the working group emphatically argues against the reduction or closure of any of London's existing clinics pending further studies. It also calls for improvements in liaison between those working with drug misuers, invites drug treatment clinics to review their role, and expresses regret that, under the present financial restrictions, there is little hope of any significant increase in the resources devoted to services for drug misuers.

*** Advisory Council on the Misuse of Drugs — Treatment and Rehabilitation Working Group. First Interim Report, September 1977. Department of Health and Social Security, Alexander Fleming House, Elephant and Castle, London SE1, England.**

Amphetamine restriction increases

WASHINGTON — The United States Food and Drug Administration proposes to ban the use of amphetamines for weight control and limit production only for cases of narcolepsy and hyperkinesis.

The FDA, which will hold a hearing in December on the proposal, said amphetamines proved "trivial" in weight control and abuse of the drug continues despite tighter controls.

Chemical unknowns

MONTREAL — Virtually nothing is known about the harmful effects on body tissue of more than 5,000 chemicals that will be marketed in North America this year. The same applies to thousands of chemicals marketed last year and the year before, states one of Canada's leading toxicologists.

"Canada is particularly lacking in such expertise," Donald Ecobichon of McGill University, told The Journal. "Experts in toxicology are needed in order to investigate the problems associated with many of these substances."

In order to do something about this, McGill's department of pharmacology and therapeutics will offer Canada's first PhD training program in toxicology, headed by Dr Ecobichon.

"The program has been introduced because of increasing concern on all sides," he said.

There will be emphasis on environmental (industrial and agricultural) chemicals and the program will be funded by Quebec.

Substance abuse: common sense is key tactic

DETROIT — Common sense, rather than any attempt at prohibition or scare tactics, is the only sensible basis for countries to use in dealing with substance abuse.

Peter Schioler, chief consultant to the Danish Minister of Education on abuse problems, believes this must apply not only to alcohol, but to tobacco, and prescribed and illegal drugs.

He told the annual meeting of the Alcohol and Drug Problems Association meeting here his work in Denmark and frequent travels abroad have left him with no hesitation: "Prohibition is out of the question."

It is estimated some 95% of all adult Danes drink. "We don't tell people not to drink, because we know they are going to drink. Our aim is to give them knowledge about what it really means to do so."

This can lead to a consensus on some questions, Dr Schioler continued.

"Almost all Danes agree driving after drinking is ridiculous, unintelligent, and disgusting. People who do it are held in contempt, and we put them in prison for quite severe terms."

Dr Schioler said to talk about demand reduction for alcohol and to try and separate it from other drugs has no meaning.

"Take tobacco and heroin, for example. We have seen the price of tobacco rise faster than wages. No matter what the price of heroin, it has no real effect on those people who really want it."

Dr Schioler, who has acted as consultant here to the Education Commission of the States, said an estimated 60% of the American population drinks. "Any dream of having an abstaining generation growing up is simply artificial."

What is needed is basic research into norms and values within a society "before we are able to say we can prevent anything.

"The measure of good prevention may be the measurement of change in behavior when the individual uses any of these groups of drugs."

The basic concept must always be a belief in human dignity. "We cannot do broad prevention in the world without believing in human dignity, and common sense, and appealing to it, Dr Schioler added.

"Many people have forgotten this in the search for cost-benefit and the fact that if they are involved in a program they want results in one or two years."

One area in which political philosophy can play a part in international efforts is in the narcotics field.

"The one effective international policy agency is the American Drug Enforcement Administration, and I have the greatest respect for it. Unfortunately, international police work tends not to be too popular with many politically minded populations, including the peaceful old democracies in Northwest Europe."

It is only because the United States and Canada put up most of the money that the United Nations Fund for Drug Abuse Control is as effective as it is.

Soccer tackles smokers

LONDON— The British anti-smoking lobby group, Action on Smoking and Health (ASH), had the support of First Division Football (Soccer) league leaders, Manchester City, when it formed a new regional branch in the North-west.

Secretary of ASH, Dr Keith Ball, said that although cigarette smoking was declining in Britain, the North-west had among the highest cigarette consumption rates in the country.

At the inaugural meeting of the new branch, Manchester City Football club's physiotherapist, Freddie Griffiths, spoke on "Smoking or Fitness" while several non-smoking members of the team explained their opposition to the habit.

One, Joe Corrigan, said: "Smoking is the most expensive way of dying that I have ever come across." Another, Dennis Tueart, said: "Both my parents smoke. I have seen my father ruin his health through smoking. It is a drug and a killer — a most repulsive habit."

Acting chairman of the new branch, Sidney Hamburger, said: "People living in the North-west die, on average, 18 months earlier than those living in other parts of the country. Much of this difference may well be attributable to the high rate of cigarette smoking in the region."

US building cocaine policy clearing up 'the fuzzy past'

(from page 1)

No proposal has been submitted yet, as far as he knows.

A great deal of effort is now going into formulating an official policy on cocaine, Dr Bourne continued.

"The federal government position has been fuzzy in the past, and there are no easy solutions on how to tackle cocaine. We hope shortly to have a precise statement on what our policy on cocaine should be — treatment, rehabilitation, international control, and law enforcement."

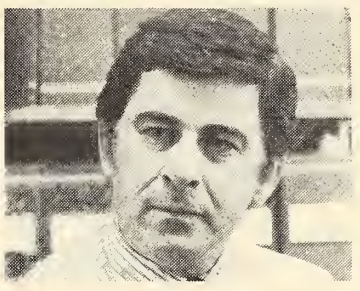
Purity of street heroin has dropped steadily over the past 12 months. "Although it isn't popular to link drug treatment with crime rates, Federal Bureau of Investigation statistics just released parallel, as they always have, the purity of street heroin, and crime statistics dropped dramatically last year."

Dr Bourne said while restrictions on the use of barbiturates are under close study, removing them from the market is only one of many options.

Much of the anxiety that has arisen in the medical profession stemmed from one of President Jimmy Carter's telephone interview programs. The previous day Dr Bourne said he had briefed him in a most general way on the problem, but the President told a questioner barbiturates would be taken off the market.

"The next day I think every epileptic in the country called me, and we had all kinds of problems," he added.

"What we have done now is approach it in a systematic and careful way, looking not only at which drugs cause the problems, but also what are all the alternatives that could be considered in terms of reducing the misuse of these drugs."



Peter Bourne

Jimmy Carter

UK health planners scan 1980s

Alcoholics may occupy 25% of beds

LONDON — If present trends continue, more than 25% of Britain's psychiatric hospital beds will be occupied by alcholics in the 1980s, so health planners are seeking new strategies to meet the problem.

The Mental Health Foundation, which provides nearly £100,000 annually "to sponsor new ways of preventing mental disorders or improving methods of care through community action," firmly believes prevention and self-help are more effective than crisis intervention.

This was made clear at a recent Mental Health Foundation conference at Magdalen College, Oxford, when a group psychotherapeutic approach known as LIBRA was described.

Lucy Younger told the conference the validity of both the disease and the psychological models as the sole explanation of the etiology of alcoholism had increasingly been questioned, turning attention to the social model.

Occupational and racial drinking habits, economic factors, availability, advertising, and the breakdown of family ties had been shown to be significant in both drink and drug abuse.

Ms Younger said it was increasingly accepted by professionals in the field that the best results would be achieved by involving the problem drinker's family, friends, and workmates as well as recovered alcoholics in treatment.

"It is also now widely accepted that treatment is more likely to succeed if it is available to the individual while he remains in his home environment rather than within an institution," she said.

Paralleling these changing perspectives had been a growing interest in groups and these were seen as particularly suited to meeting the needs of problem drinkers who tended to be intolerant, defiant, and poor at relating.

Problem drinkers were more likely to understand and modify these traits if they saw their own difficulties reflected in the experience of others. The group process could help people to tolerate frustration, help others, and regain self respect.

After giving this background to the development of the LIBRA group, Ms Younger said it had been started five years ago after an unnamed consultant psychiatrist, Dr L, found that no available facilities offered effective treatment to one of his alcholic patients.

The psychiatrist suggested the formation of a group of middle-aged problem drinkers including his patient — and LIBRA was born.

Ms Younger told the conference the group included several people with severe alcohol problems and in-patient experience who felt they had not benefited from available treatment facilities, including Alcoholics Anonymous, sufficiently to maintain a satisfactory life in the community.

"As well as the importance of including relatives and any other interested people in the group and of basing it on the community rather than an institution, Dr L and his patient emphasized two key factors:

1) the group is one where all members teach and learn from each other;

2) the group should not reject members, even if they are drinking or actually turning up drunk, on the grounds that abstinence is not necessarily the only measure of desire for recovery.

The attendance at LIBRA meetings was about 12 weekly although the number of people actually in contact with the group was much higher. The meetings were held in the home of the original patient of Dr L and telephone contact between members was maintained between meetings.

Ms Younger concluded LIBRA had provided a relationship network both within and outside the group which had helped to prevent crises and could use professional services without becoming overdependent upon them.

"Much more could be done to integrate those with drug problems with those with an alcohol problem; also to integrate spouses and to reach people early in order to prevent breakdown," she said.

LIBRA: An experimental approach to the problems of alcohol abuse — Mental Health Foundation, 8 Wimpole Street, London W1M 8HY.

New test diagnoses alcoholism

TOKYO — Doctors at the Max-Planck Institute for Psychiatry have developed a new test for the diagnosis of alcoholism.

Called "The Munich Alcoholism Test", it allows reliable differentiation between alcoholics and healthy as well as sick persons, and is easy to administer, W. Feuerlein told delegates at the International Medical Symposium on Alcohol and Drug Dependence here.

The test was developed from 250 diagnostically relevant items selected from the literature on alcoholism, and was evaluated in three phases with 1,335 patients, 661 of whom were alcoholics, for its ability to differentiate each group.

The best items were selected on the basis of statistical criteria and were then cross-validated, said Dr Feuerlein.

The tests consist of two complementary parts: a seven-item physician's assessment and a 24-item self-assessment part.

In the cross validation study on 675 randomly selected inpatients and outpatients, validity of r = .94 was obtained.

The reliability of the self-assessment portion was r = .84.

A scale for alcoholics has also been developed by a group of Japanese workers.

The new scale can discriminate between alcoholics and non-alcoholics with an accuracy of 98.5%.

It was tested on 1,182 men and women ranging in age from 15 to 69 years.

Further tests were then done on 253 former alcoholics and 608 normal drinkers, and a discriminant function was made using the load items as explanatory functions. A high degree of concurrence was noted.

Antabuse -- deformity link

MONTREAL — Limb deformities in two babies born to mothers on Antabuse have been noted at the University of Colorado Medical Centre, Denver.

Dr James Nora, taking part in discussion of fetal alcohol syndrome papers at the 5th International Conference on Birth Defects, said he knew of no published reports linking Antabuse to such anomalies. But he wanted to bring his centre's two cases to the attention of those attending the meeting because many were involved in treatment of alcoholic women.

One baby had an abnormally short forearm, the other was born with phocomelia, the flipper-like limbs that were frequently seen in babies whose mothers took thalidomide during early pregnancy.

Kiwi women smoking

AUCKLAND, NZ — Young women in New Zealand appear to be smoking in greater numbers and more heavily than in the past, although the number of male smokers is decreasing.

These trends are evident in provisional statistics from the 1976 census, which show overall percentages of cigarette smokers as 38.5% for men and 30.5% for women, according to the health department.

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More movement on 'revolving door,' please

The Journal is very informative and I enjoy reading it. However, there is a surprising dearth of articles regarding the treatment and social control of chronic alcoholics, sometimes referred to as "revolving door" alcoholics. In the two years I have subscribed to **The Journal**, there have been only a few items about this population, and they left a number of questions unanswered, in particular, "What were the sources of referrals to programs for the chronic recidivists?" The articles do not usually mention whether chronic alcoholics participating in residential and/or work programs are volunteers or court referrals.

In states (and provinces?) where alcoholism has been decriminalized, what agencies of social control have replaced the jails? Are chronic alcoholics subsidized by the welfare system in other places as they are in the state of Washington? In this era of civil rights emphasis, how is involuntary commitment faring as a way of dealing with the incompetent chronic alcoholic?

It is understandable that emphasis should be on treatment of those in the earlier stages of alcoholism, who have a much better chance of recovery. But the chronic alcoholic minority utilize an enormously disproportionate share of alcoholism and other social resources, notably medical and legal.

The head of King County Division of Alcoholism Services says he patterned Seattle's van pick-up service after a similar service in Minneapolis. There is a need for more of such exchange of ideas and methods of dealing with this multi-problem population, more hard-figure-and-fact articles. I'll be hoping to see them.

P. Simmerer
Seattle, Wash 98112

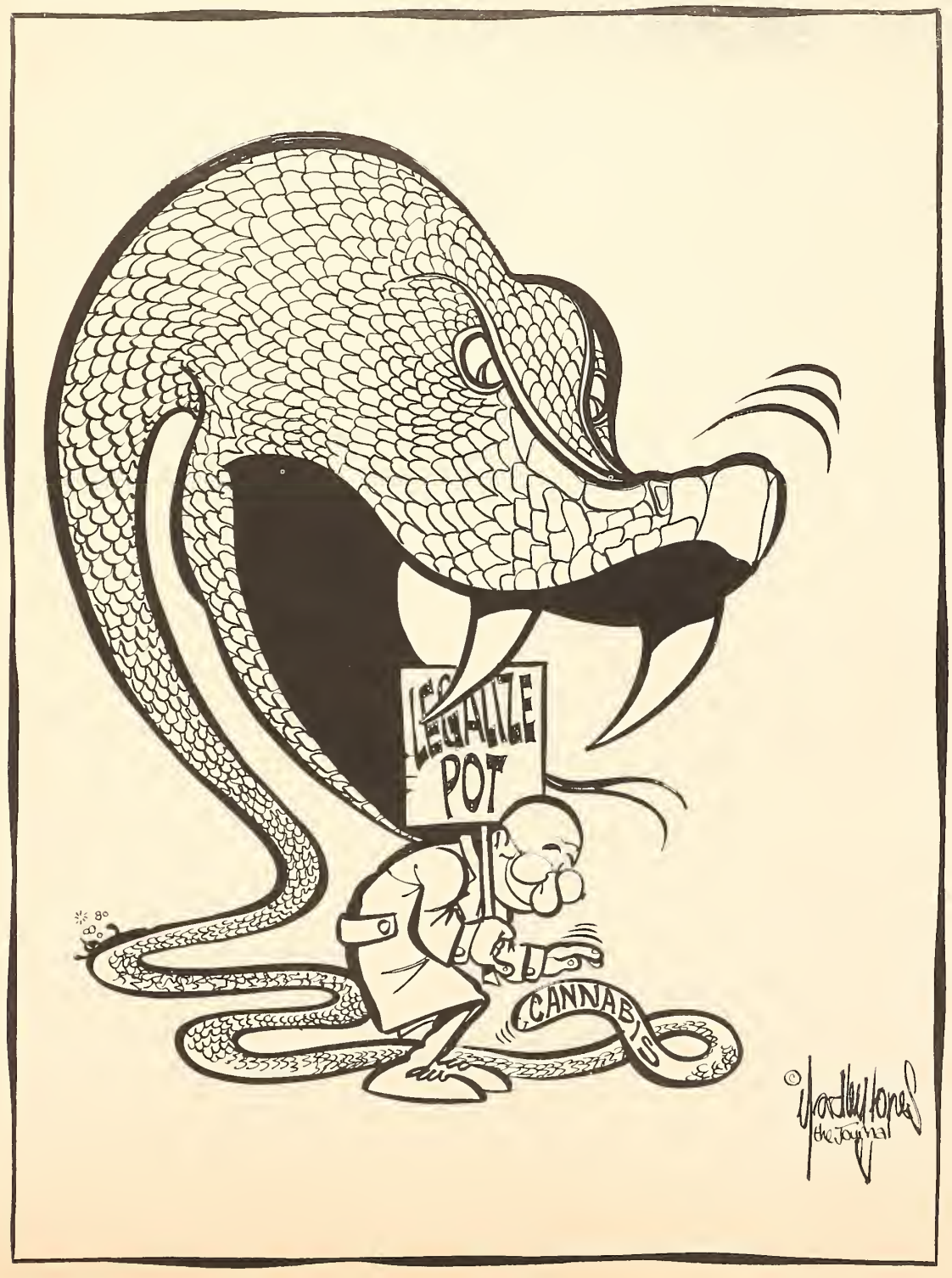
Following Ontario

As a long time recipient of **The Journal**, I was especially interested in the article by Martha Sanchez-Craig, CDOs — A Way To Refine The System, The Back Page of your September issue.

The article refers to the Task Force II Report on the Ontario Detoxification System (1976). We are beginning a two-year pilot program in Sacramento County for the state of California based on similar premises. If the pilot is successful, the entire state hopes to introduce this approach to the public inebriate.

The Journal continues to fill a genuine need in society's constant effort to find answers to this most perplexing of human problems.

James J. Boock, Member
Sacramento County
Alcoholism Board
Sacramento, CA



Drug scene will change constantly

Thank you for your article Clarification for San Francisco which appeared in **The Journal** (Oct) and reconciled the apparent conflict between the Haight Ashbury Free Medical Clinic's heroin epidemiology figures and those of the National Institute on Drug Abuse.

The study of the incidence and prevalence of heroin addiction in any particular region of the country is an improving but still rather subjective art.

Nevertheless, NIDA's "heroin rankings" are, in my opinion, accurate qualitatively but were vigorously attacked in San Francisco since it is threatening to local Bay Area politicians to be No 1 during an election year.

It is important to keep this comparison in perspective however. The heroin problem in the Bay Area is relatively stable and in certain regions is actually declining where other drug problems such as alcohol, PCP, and Ritalin are on the increase.

It is apparent the only constant about the drug scene is that it will change. And it is essential that treatment programs be flexible in order effectively to respond to new drug patterns.

Heroin addiction is here to stay but it is certainly not "the only show in town".

David E. Smith
Medical Director
Haight Ashbury
Free Medical Clinic,
San Francisco, California

AA's only first step

I want to say that I believe it's possible to leave Alcoholics Anonymous, venture out quite alone in the world, and have a very meaningful life.

I was an alcoholic for several years. I became very ill — thankfully — and this gave me time to dry out. Incredibly, my brain which had just been vegetating, began to function again. It is this, more than anything else, that has kept me from drinking again (2½ years).

I attended many AA meetings but began to notice that:
1) it was only at these meetings I even thought of liquor;
2) the exact same people continue to attend these meetings — not just for a few months: it becomes their way of life. Certainly better than drinking;
3) once I learned the 12 steps — really learned them — I wanted to branch out. I wanted to go forward, do things on my own, learn new crafts, etc.
4) I believe AA is a vital first step but should only be a stepping stone. I found none of this. No one is encouraged to go it alone. These people live only for their meetings — make friends only with other alcoholics.

I feel this is a dreadful state for it would appear these people have substituted alcohol for another type of addiction — the continual meeting. They are, in fact, afraid to face the world and its responsibilities.

I am not running down AA for certainly it has done more good than any doctor or psychiatrist. I only feel the program is not carried out as successfully as it could be.

I know most people disagree with me but there are many of us who feel this way.

Patricia Armstrong
Vancouver, BC

Good things I may miss

. . . There are so many good things in **The Journal**, once in a while I miss something I should have seen for we are very much interested in the problems of parents and young people. We have a family group, a parents group, and a couples group in connection with our rehabilitation program which is known in these parts as Little Hill-Alina Lodge. God bless.

Geraldine O. Delaney
Executive Director
Little Hill Foundation, Inc.
Blairstown, N.J 07825

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1. We reserve the right to edit all correspondence.

Inside Science

How RIDE may deter the drinking driver

By Pamela Ennis*

THE DESIGN of effective countermeasures poses a considerable challenge to those concerned with reducing alcohol-related damage on our highways.

For some time, it has been recognized drinking-driving is a disproportionately large contributor to highway accidents and fatalities. In Ontario during 1976 — the most recent year for which we have information — 54 out of every 100 drivers *killed* in collisions had been drinking. A recent roadside survey conducted by the federal government found that during the evening hours, one in five drivers had been drinking and 6% were legally impaired (« .08%). In addition, more people are charged with alcohol-related traffic offences than with almost any other Criminal Code offence.

What is most staggering is that these statistics reflect only the tip of the iceberg. Epidemiological studies have shown that only a small proportion of persons arrested for drinking-driving offences in a given year are likely to be recidivists or to become recidivists in the future. The overwhelming majority of people apprehended for impaired driving are first-time *arrestees* for that offence. This does not mean they are first-time offenders, however, since the probability of being apprehended is so low. It is clear that we need large-scale countermeasures directed at that sector of the drinking-driving population that as yet has not been caught.

The RIDE program (Reduce Impaired Driving in Etobicoke) is a drinking-driving countermeasure that is aimed at deterring that large sector of the population who are potential drinking drivers, as well as detecting and apprehending drinking drivers who are already on the roads before they have an accident. To achieve these aims, it is necessary to increase not only the actual chance of being caught (objective probability of apprehension) but also peoples' *beliefs* that they will, in fact, be caught if they drink and drive (subjective probability of apprehension). A delicate balance exists between these two concepts. Simply to increase the subjective probability of being caught by means of a public education program without increasing the objective probability of being caught would likely have a short-term effect only. So long as the probability of detection is low, the expectation of being hurt by the law enforcement process on any given occasion will be so small as to thwart deterrence.

The major obstacle in the path of efficient enforcement is the fact that detection of the drinking driver is really a chance event. Detection procedures are such that only the worst cases are likely to catch the attention of the police. In general, drinking drivers are stopped because of some aberrant driving behavior or involvement in accidents. Yet other drinking drivers, potentially just as dangerous, are disregarded because they do not conform to this pattern. A routine patrol in which only classical symbolists are removed from the traffic flow is not fulfilling its preventive function. What is needed is a policy of rotating spot checks for detecting drinking drivers, with greater use made of the roadside breath-testing provisions in the Criminal Code. Such procedures make police enforcement of drinking-driving laws a highly visible activity. The objective probability (actual chance) of an impaired driver being stopped is substantially increased. It is imperative that we apprehend those drinking drivers who might otherwise remain unnoticed when more traditional enforcement practices are employed. Also, simply seeing police stop other drivers can greatly increase a driver's subjective estimates of being stopped and charged himself.

The RIDE program involves strategies of primary intervention (education) and secondary intervention (specific enforcement) aimed at increasing both the objective and subjective probabilities of apprehension.

Beginning October 1, 1977, for a period of one year, spot checks are being held at over 100 locations in Etobicoke. These locations were selected on the basis of high visibility, high traffic flow, and frequency of drinking-driving offences and accidents. Each day for 16 hours, two shifts of six officers each set up spot checks at up to 20 randomly chosen sites. The emphasis is on rotation among these locations. Stopped motorists are asked to produce their licences, and those who appear to have been drinking are required to take a roadside breath test. Should the individual fail this test, he is taken to the police station for a breath test. In addition, officers radio in to police headquarters to determine if the driver has any outstanding charges or fines against him. All motorists receive a pamphlet on the RIDE program and drinking-driving at the end of the spot check procedure.

To accompany this enforcement activity, a large-scale public education campaign is being conducted during the month of October. All Etobicoke households have received public information materials on drinking-driving and the RIDE program has enjoyed extensive media coverage.

In addition, safety displays have been set up by the police at local shopping plazas, and a fairly intensive public speaking schedule has been slated for service clubs, high schools, church groups, and other community organizations. While it is hoped these materials will help to increase public knowledge about drinking-driving, the main objective of this educational activity is to inform people that their chances of being apprehended have substantially increased.

RIDE is not only a community project but a research project as well. Evaluation has been built into the program from the beginning. The ultimate criterion of program success will be a reduction in alcohol-related traffic accidents in Etobicoke. It is also hoped the number of drinking-driving charges, as well as average BAC levels, will decline. A final goal would be to achieve a significant increase in public knowledge on all aspects of drinking-driving.

While there is no easy solution to the drinking-driving problem, one point seems to be clear. People must be made aware that drinking-driving is not an issue that only concerns 'the other guy'. Rather, we all must be responsible for preventing alcohol-related damage on our highways. It is hoped, given the fact that 500-600 motorists are being stopped at spot checks every day in Etobicoke, this message will be driven home to borough residents.

*** (Dr Ennis is a scientist in the evaluation studies department of the Addiction Research Foundation of Ontario).**

Photos: Bill Sandford/The Etobicoke Gazette

Change

WITH THIS issue, The Journal **begins printing on significantly higher quality newsprint than previously. In addition to enhancing the immediate appearance of** The Journal, **the new paper stock will also ensure the publication a longer shelf-life. This is but one reflection of our efforts to keep improving service and we hope readers welcome the change.**

Jean McCann reports from
a NATO Conference
on Experimental and Behavioral Approaches
to Alcoholism
held in Os, Norway

Mass screening may find abusive drinkers early on

A MASS screening test which would permit physicians to find abusive drinkers earlier in their drinking careers is one aim of research now going on at the National Institute on Alcohol Abuse and Alcoholism, Ernest P. Noble, director, told the conference.

Dr Noble said preliminary research shows mean corpuscular volume measurement may be significant in picking out heavy drinkers.

"In one investigation at NIAAA, 25 routine blood chemistry tests were given to two groups of patients, one known to be alcoholic, and the other reporting no abusive drinking. Differences in test results allowed our investigator to achieve 96% accuracy in distinguishing alcoholic people from non-alcoholic ones, and the single most significant differential blood test was mean corpuscular volume. The potential of this work for developing a mass screening device to discover heavy alcohol consumption is tremendous," he added.

Ernest Noble

"For researchers, it carries the added promise that you may some day have a population that has hitherto been unavailable to you for study . . . persons in the prodromal stages of alcohol dependency."

For the physician, such a test would not only detect alcoholism earlier, with its many attendant medical problems, it would also enable him or her — or other individuals treating alcoholics — to follow the progress of rehabilitation. Doctors need such a tool, he said, because without objective evidence that a patient is drinking excessively, "many persons will either deny or understate their alcohol consumption when questioned by their physician."

Speaking on new directions in alcoholism research, Dr Noble also mentioned the need for more objective evidence on the relationship between drinking and cancer, drinking and heart disease, and drinking and longevity, for instance — in much the same way there is now objective evidence alcohol abuse causes birth defects. With more scientific input like this, he said, "after taking a patient's history, a physician can counsel a patient who may be predisposed to alcoholism, or an alcohol-related condition."

Dr Noble also sees the need for "a drug that will ease the pain and danger of the alcohol withdrawal syndrome" without the serious side effects of some of the drugs now in use. Another drug needed, he said, is one which would "speed the process of sobering up," and could be stocked in emergency rooms.

Research also is needed on the effect of alcohol on the reproductive and endocrine systems, he said. Already, it is known heavy-drinking men may become impotent, and there is now evidence women alcoholics don't ovulate in a normal way.

"Researchers in our institute have gathered laboratory evidence of this. They gave a group of regularly ovulating female rats a daily dose of 8 gram per k of ethanol intragastrically, which is the equivalent in humans of around 4/5 of a quart. Eighty per cent of these animals stopped ovulating."

Since more women now seem to be drinking heavily today, it is important to get more answers, he said.

"Should research turn up more definitive evidence that heavy drinking results in loss of ovarian function, physicians would then be on solid ground to advise women of child bearing age who abuse alcohol to quit drinking and accept treatment if they want to bear children again. The sudden onset of amenorrhea in women patients still in their reproductive years can also alert a family physician to possible heavy alcohol intake, thus serving as a case-finding device."

Other problems needing attention are alcohol-related social problems involving crime, car accidents, and family and job troubles. "Our knowledge of these remains sketchy. We know, for example, that when people consume from six to 10 drinks per occasion, they are more likely to enter these problem-related areas. But we do not know whether, or at what level, social drinking becomes implicated.

"Neither do we know whether the various alcohol-related social problems tend to cluster in the same people, or whether they may be separate phenomenon related to personality or life situations. Those who have alcohol-implicated motor vehicle accidents may not be the same people who are seen in hospitals with cirrhosis, for example."

Family patterns no real indicator

PROBLEM DRINKERS do not necessarily come from families with other alcoholics in them, despite the common belief, suggests a study of 1,130 patients treated at the Fort Logan Mental Health Center in Colorado.

John Horn of the University of Denver told the conference that "less than 15% of the patients entering the facility for treatment of alcoholism report their parents were problem drinkers, and less than 20% report anyone in their immediate family had a drinking problem."

In this fairly large sample, there is thus "no support for any hypothesis that such patients necessarily, or even frequently, developed in families in which the members had drinking problems," he said.

Factors which did show a high correlation with problem drinking, however, included a person's alienation from his/her own culture such as a rural Indian moved to the city, few means for maintaining a decent livelihood, and living alone and unmarried.

Hard-drinking individuals in this study also showed themselves to be angry, untrusting, unsociable, anxious, and rebellious, and these traits were shown most often by the Hispanics and blacks in the Denver area.

Another "face of alcoholism" was more often shown by a Hispanic or white woman in an unhappy love relationship, who used alcohol "as a medicine to deal with emotional problems and doubts about self-worth."

Alcohol was also shown in this study to be used by some to overcome shyness, lack of self-confidence and decisiveness, anxiety, mistrust of others, and "strange, unusual thoughts."

An improvement in sociability was another aim in alcohol use, and "the pattern in this case appears to be one associated with that kind of loneliness that comes from not having had rewarding interactions in the family of origin," Dr Horn said.

"Now, in the present, drinking and the conviviality of the bar are being used to make up for the past and to establish a place in a social group wherein one can enjoy and be appreciated."

Dr Horn said these different "faces of alcoholism" must be taken into account in devising individualized treatment programs.

Battery testing as aids

A BATTERY of psychological tests may indicate whether an alcoholic is motivated to begin treatment, but it doesn't appear to help answer whether the patient needs abstinence or controlled drinking as a goal.

This was the conclusion of a study of 154 chronic male alcoholics admitted to the Charleston, South Carolina Veterans Administration Hospital substance abuse ward for detoxification.

The chief motivation for treatment, the study showed, was "subjective distress."

"Alcoholics, be they advocates of controlled drinking or abstinence, who are willing to participate in treatment for their problem drinking, report themselves to be experiencing considerable subjective distress. They report themselves to be high in A-trait, high in A-state at the time of testing, high in emotional lability as measured by the Eysenck neuroticism scale, higher in social-interpersonal, miscellaneous, and failure-loss of self-esteem fears, higher on the MMPI psychasthenia scale, which contains a large anxiety component, and higher on the mood state measure of tension-anxiety."

Individuals motivated for treatment also showed "greater depression as measured by the MMPI, and mood disturbances of depression-dejection, fatigue-inertia, and confusion-bewilderment, as well as less vigor-activity as measured by the Profile of Mood states scale," Dean G. Kilpatrick said.

Individuals who were not motivated, he added, scored higher in field dependency which is hard to fake, higher in lie scores on the MMPI, reflecting a general lack of candor. "Field dependence thus may prove useful in detection of denial of problems, or lack of candor."

Dr Kilpatrick said the study also showed that "while the assessment battery proved useful as a screening device, the need for careful behavioral assessment, including gathering information from collateral sources, is clearly indicated."

Drinking and delinquency

THE EARLIER a man starts to drink, the more likely he is to be involved in delinquent behavior, according to a University of Michigan study.

Louis Van Rooijen told the conference that those of 289 alcoholic men who began drinking before age 17 had a much higher level of delinquency during adolesence, and unlawful behavior in adulthood, as compared to those who began drinking between ages 17 and 19 (the intermediate starters) and those who started at 20 or more (the late starters).

"Analyses of self-reports showed the earlier the men started drinking, the lower their levels on the California Psychological Inventory constructs of socialization, responsibility, and self-control, and the higher their levels of general and violent aggression, general delinquency during adolescence, and self-reported arrests.

"Analyses of the driving and criminal records also indicated early and intermediate starters showed higher levels of hazardous driving behavior and general criminality than late starters."

Norwegian finds in double-blind trial

Beta blocker controls withdrawal

ABSTINENCE SYMPTOMS in cases of chronic alcoholism can be successfully treated with a beta blocker, a Norwegian study has found.

Oyvind Digrane, consultant to the Hjellstad-Klinniken, a hospital for alcoholism and drug abuse in Norway, said the beta blocker pindolol, or Visken was successfully used in a double blind trial to overcome a prolonged reaction to alcohol withdrawal.

"Not infrequently, a protracted abstinence phase with pronounced hyperkinetic symptoms involving tremor, tachycardia, hypertonicity, anxiety, and perspiration is experienced, despite our usual treatment, which consists of a combination of opripramolchloride, and Fenemal, the latter as a supplementary drug to reduce the tendency to abstinence cramps which occurs, untreated, in about 10% of cases," he said.

"Since heightened catecholamines have been found in the plasma and urine of alcoholics in the abstinence phase, besides heightened minute volume, it appears logical to treat these symptoms by Betarespto-blockers.

"Apart from the indications that have gradually been established, such as angina pectoris, hypertonicity, and cardiac arrythmias, Beta blockers have been employed in psychiatry in recent years for anxiety disorders, for essential benign tremor, and to alleviate stage fright, which is often caused by heightened sympathetic tonus."

His study involved 112 alcoholics aged 20 to 60.

"As soon as they were sober and developed early abstinence symptoms, they were given Visken, at a dosage of 5 mg three times a day, or a placebo.

"Results showed that blood pressure dropped more quickly in the therapy group, which was particularly noticeable in the standing position, while it tended to rise in the placebo group. Pulse counts also showed a quicker drop in the therapy as against the placebo group, and tremor especially improved far more quickly."

Anxiety was also reduced in the treatment group, he said, but there was little difference in the two groups in the perspiration tendency.

In terms of side effects, "one patient tended to have nightmarish dreams at night, which ceased spontaneously without any change of dose. Otherwise, we sought to avoid the tendency to nightmares by administering the last dose at 4 pm".

Because of the success of the study, he said the beta blocker is now routinely used in patients with anxiety, tremor, perspiration, palpitation, and high blood pressures. Usually the drug is given over a period of two to three weeks, but about 10% of the patients are discharged on long-term Visken treatment.

The drug has now been used in more than 500 patients, and "the experience is still good", he said. Not only does the drug take effect quickly and the halving time is short, but "the substance is largely excreted renally, an obvious advantage because this particular group of patients often have indications of toxic liver disorders."

Dr Digrane said it will be interesting to see if its use reduces recidivism in alcoholism.

Low tar, high nicotine mix

For 'can't stop' smokers, change the cigarette

LONDON — Most family physicians in Britain do little more than nod sympathetically when a patient advised to quit smoking confesses he is unable to do so.

Referral to a smoking withdrawal clinic passes the buck nicely, but the success rate for these institutions is far from impressive. The best in London scores 30% off the weed after one year (i.e. a 70% failure rate at one year, and probably even higher later).

So it may come as a suprise to learn that a London psychiatrist who has spent some years studying the smoking habit is far from pessimistic about the prospects for beating tobacco addiction.

Michael Russell's office is in a building beside the famous Maudsley psychiatric hospital, Denmark Hill, South London — part of the Institute of Psychiatry's Addiction Research Unit.

It is modest in size — considering the size of the problem — and decorated with a connoisseur's selection of anti-smoking posters from various corners of the world.

Dr Russell told **The Journal**: "I am particularly interested in the importance of nicotine and the possibility of developing safer smoking."

"The chance of substantially reducing the number of smokers is going to be slim in my view and anyway it is going to be a long slow grind. I am not saying that we shouldn't work in that direction, but despite the example of British doctors, we will not see large numbers of people giving up the habit easily, particularly those in the lower social groups."

Dr Russell's approach to safer smoking eontrasts with current trends (with the introduction of the cellulose-based New Smoking Material) towards low tar, low nicotine smoking. He wants to see low tar *medium to high nicotine* smokes on the market place.

New Smoking Material, he says, is simply a device for diluting tobacco smoke — an objective which can easily be achieved with better filters.

If, as Dr Russell suggests, nicotine addiction maintains the habit for many smokers, they will be inclined, merely, to smoke more of the new milder NSM brands.

Instead, Dr Russell would like to see the introduction of a "niee innocuous" (in terms of tar production) cigarette, adequately laced with nicotine.

He argues that compared with tar, which is linked with cancer and carbon monoxide which may provoke heart problems, nicotine has relatively minor contra-indications for the majority of smokers.

"If you suddenly found half the population going down with lead poisoning and found that it corresponded with alcohol consumption you would not stop people drinking, you would try to get the lead out of the alcoholic beverages," he said.

"But the tobacco companies are not approaching it this way. They have been selectively breeding tobacco plants for low nicotine content."

Until the medium to high nicotine, low tar cigarette appears on the market, Dr Russell believes doctors should use all the anti-smoking aids available. He particularly favors the nicotine-laced chewing gum which some British smoking withdrawal clinics have been allowed to introduce experimentally.

He said he hoped nicotine chewing gum will soon pass the stringent requirements of the British drug watchdog — the Committee on Safety of Medicines — so it can be made widely available.

Dr Russell does recognize that nicotine-laced substitutes for smoking must be approached with caution, however. He would like to see the gum supplied on prescription.

Ideally, he would like to see family physicians take a much more active role in tackling the smoking problem. Britain's general practitioners (as family physicians are called over here) have aeeess to the great majority of smokers (93% of the population visits a GP once in every five years) and if every family doctor could persuade one person a week to stop smoking it would represent a "seore of a million British ex-smokers annually.

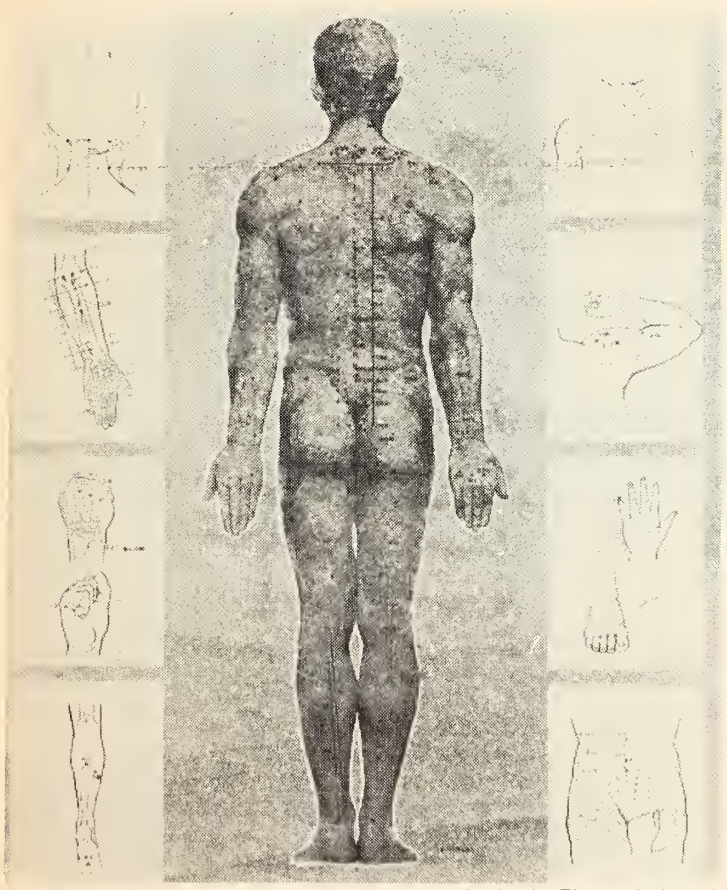
"To aehieve the same result by referring smokers to smoking withdrawal clinies you would have to open 10,000 new clinics at the current success rate," he said.

NIDA finances acupuncture study with addicts

By Lachlan MacQuarrie

HONG KONG — The United States National Institute on Drug Abuse is providing US $100,000 owards a major study of the application of aeupuncture with electrical stimulation (AES) in the treatment of narcotic dependents on an out-patient detoxification basis in Hong Kong.

To carry out this study, the world's first out-patient AES treatment centre has been opened at the Tung Wah Hospital here. In charge of the pilot project is Dr H. L. Wen, whose initial work on the effeets of AES treatment were first reported in **The Journal** in June, 1973.



A chart showing major acupuncture spots on the body. The technique is being combined with electrical stimulation in an attempt to help addicts in Hong Kong.

Dr Wen has stated the specific objectives of his study are "to examine whether out-patient acupuncture detoxification (OAD) is aceeptable to a large number of narcotie dependents in Hong Kong as a voluntary treatment; whether OAD ean relieve withdrawal symptoms from physical dependence on nareotics; whether OAD together with the neeessary supportive services can contribute to social rehabilitation of narcotics dependents; whether eontinued application of AES can block the craving for opiate drugs and prevent relapse; and whether OAD plus AES follow-up can compare with other forms of treatment programs in Hong Kong, medically, in eost-effectiveness, and in ability to treat a large number of addicts."

The AES technique to be used in the study will be similar to Dr Wen's earlier methods in which a five to six volt current at a frequency of 125 Herts will be applied through a pair of aeupuncture needles inserted bilaterally into the concha of the car.

Patients in the pilot study, all of whom will be volunteers, will be divided into six different treatment groups. The minimum size of each group will be 75. The first group will be treated by AES alone and the seeond on AES, preceded by three days of methadone stabilization at 20 mg twiee a day. The third group will be on AES supplemented by seven days of methadone weaning, and the fourth group will have AES plus 14 days of methadone weaning.

The two other groups whieh will figure in the study will be patients in programs already operating under the aegis of the Hong Kong Medical and Health Department. One group will eome from the Methadone Maintenance Program and the other from the Ambulatory Methadone Detoxifieation Program.

Upon admission to one of the treatment groups, each patient will be interviewed by a soeial worker and his personal particulars together with his eomplete soeial and addiction histories will be recorded. In addition, a full medical check will be earried out.

After admission, all clients will be observed once a day on the basis of a symptom cheek list and a self-rating questionnaire on individual feelings. There will be statistical analyses of personal particulars and admission and retention rates, as well as intergroup comparisons with regard to withdrawal symptoms and suceess of treatment.

"If positive results are seen in some of our areas of study" states Dr Wen, "AES could offer a number of important benefits. It is easy to administer. It is cheaper than most current addiction treatment programs. If no opiate drugs need to be used in relieving withdrawal symptoms, patients need not be eoncerned about beeoming addieted to any other drug. Control problems are eliminated. Counselling can be carried out during treatment as patients are alert and general well being is good."

Hungary bans smoking ads

BUDAPEST — Hungary's Ministry of Domestic Trade has banned advertising of cigarettes and other tobacco industry products in a new national drive to discourage smoking. The ban applies to all forms of advertising.

Under the ruling, no new advertisements may be accepted by the mass communication media (including posters). Existing advertisements must also be removed but, in order to honor domestic and international commercial arrangements, the deadline for this has been postponed to October 1, 1978.

Tobacco industry products displayed in the windows of shops in which they are on sale are exempted from the ban. All imported tobacco products in future will bear the name, and implied responsibility, of both the foreign makers and local importers.

Private citizens may continue to import tobacco products into Hungary in conformity with the existing customs regulations, but the sales of such products are restricted to authorized Hungarian companies. Foreigners can only sell tobacco products with permission by the Hungarian National Bank, and only to authorized firms.

Kiwis' favorite recreation

AUCKLAND, NZ. — Official support has been given to the view that drinking alcohol is New Zealand's "major recreational activity."

The health department, in its annual report, says this view can be supported by evidence of those who use alcohol (estimated at about 86% of the population over 18), the amount of alcohol consumed, and the number and variety of occasions on which drinking is an integral part (or main purpose) of festivities.

The report says experts in the field suggest there are at least 53,000 chronic alcoholics. Assuming they affect an average of 10 people, there are 500,000 New Zealanders (out of a total population of 3,100,000) affected.

Around the World

Bootleg liquor

Eighty-four people have died of poisoning after drinking illegal liquor in the Indian city of Ahmedabad in Western Gujarat. The Samachar news agency reported that after the same incident of liquor poisoning, 97 people were hospitalized in serious condition. The sale of alcohol is prohibited in Gujarat state, and illegally brewed 'hooch' is blamed for the deaths. In October, 1976, 105 people died after drinking bootleg liquor in the Indian city of Indore.

Home brew

More Britons are drinking at home, department of trade figures suggest. Sales in liquor stores are rising twice as fast as those in public houses. But Britons will keep on drinking despite the high taxes on spirits and wine: sales in publie houses are up by some 12% over last year.

Broken treaty

An advertising ban on spirits by five Freneh language eommercial radio stations has been ruled in contravention of the Common Market treaty. The five stations operate around French borders and brought in their ban in January after pressure from the French authorities. All advertising of aleoholic drinks is banned from the state-run Freneh broadcasting system. The commercial ban is unfair because it discriminates against whisky yet does not prohibit the advertising of wine, says Charles McDonald, an Irish MP in the European parliament. He has eomplained to the EEC about the radio stations whose ban included whisky, gin, vodka, Pernod, and other similar drinks. Aperitifs can be advertised subject to certain eonditions but there are no restrictions on ads for wine and some liqueurs. The EEC commission ruled in Brussels last June that the spirit advertising ban was ineompatible with the EEC treaty.

Adverse reactions

An adverse drug reaction was the major cause of hospital admission in more than 10% of elderly patients studied by doctors at the University of Edinburgh, Scotland. In all, 81% of the elderly patients were on prescribed drugs.

Team aiding gas sniffers quits after 5 months

By Manfred Jager

WINNIPEG — A young husband and wife team working at Shamattawa, Manitoba, on a long-range program aimed at helping to cure gasoline-sniffing young Indians, have resigned after only five months on the job.

Neville and Anne Sokol said in late September they resigned because of government delays in providing them with living accommodation and office space in the Indian community 230 miles northeast of Thompson. Thompson is 450 miles north of Winnipeg.

The Sokols also questioned the low priority given the project by the Non-medical Use of Drugs Directorate of the federal department of health and welfare and the department of Indian affairs.

Mr Sokol stressed the department's representative in Thompson had given him and his wife good support. However, they felt the Winnipeg branch of the directorate was weak in its support.

The Sokols had been hired by the Indian band council at Shamattawa but the program is financed by the federal government.

It is known as the Leonard Miles Memorial program, after an Indian child who died some time ago from the effects of glue sniffing.

More than 60 young people from Shamattawa have been treated in Winnipeg during the past three years — most of them for the effects of gasoline sniffing which has long been considered epidemic in Shamattawa.

Mr Sokol said he and his wife found "nothing bad" about living in Shamattawa. He said they were encouraged by the growing sense of responsibility band leaders and other local residents showed in improved community living standards.

The Sokols said they were to have been given the use of a trailer which has been sitting in the community since April, waiting to be hooked up to services.

They admitted rain in August and work on five other construction projects gave authorities some excuse for delays, "but it should have been a matter of days, not months," the couple said.

Chief Jude Miles and Bennett Redhead, the band's development officers, said the Sokols were "good people" and got on well in the community.

Mr Redhead said the delay in building a drop-in centre to prevent gasoline sniffing also demonstrated lack of concern by some government officials. The centre was to have been completed by Sept 29, but up to early October only half the foundation had been excavated.

Mr Redhead said the government agencies "try to do too much — more than they or the rest of us in the community can handle. There are so many government ideas on how we can get helped. We get pretty damn confused."

Mr Sokol said it was his and his wife's work to listen to the ideas of local people and provide leadership and encouragement for them.

The last co-ordinator, Tim Maloney, who preceded the Sokols, left Shamattawa after only a short time in the community as well.

"When people come and try to help us they don't last long, but when they do nothing at all they stay a thousand years," Mr Redhead said.

The Sokols gave the band a month's notice and said they would consider going back to Shamattawa after spending some time in Winnipeg.

Shamattawa, with its population of 550, first made headlines for its unique health problem when a number of children from the community had to be treated for lead poisoning at Winnipeg's Health Sciences Centre.

The youngsters were sniffing gasoline as a side effect of their elders' alcohol problems, community officials said.

Over 600 incidents in 1976

Drug theft from community pharmacies growing

TORONTO — Combating the diversion of drugs from community pharmacies is becoming a growing problem for Canada's narcotics control officials.

Eugene V. Wilson, PhD, says in the past four years Canada has had a major increase in thefts of narcotics and controlled substances.

"About five years ago, there were perhaps 50-60 cases of break and entry of pharmacies per year and usually only handfuls of goods were stolen. Last year, we had something in the neighbourhood of 600 of these thefts occrring after work hours, and there was also an increase in the number of armed holdups when the stores were open."

Even more disturbing, he said, is the fact armed holdups are spreading to hospitals as well.

On a more positive note, Dr Wilson told the meeting here of the International Narcotic Enforcement Officers Association that government regulations have served to correct the misuse of legal amphetamines in Canada.

Evidence of this is the fact Canadian imports of amphetamine and methamphetamine now average about 28 kilos per year as opposed to 1966 when slightly more than 1,000 kilos of amphetamine and methamphetamine were imported.

Dr Wilson, assistant director of the Bureau of Dangerous Drugs, said that in the early 1970s there was increasing evidence that legally prescribed dosage forms of amphetamines, including phenmetrazine and phendimetrazine were being abused and misused in the drug sub-culture.

As a result, in January 1973, amendments were made under Part III of the Food and Drug Regulations creating a class of drugs called designated drugs, which included all of the amphetamine and related drugs. The regulations permitted a practitioner to prescribe such a drug in the treatment of a specified condition (narcolepsy, hyperkinetic disorders in children, mental retardation, epilepsy, parkinsonism, hypotensive states associated with anesthesia, or, in animals, depression of cardiac and respiratory centres).

Since Canada is not a basic manufacturing country with respect to these drugs, Dr Wilson said the figures on the Canadian imports of amphetamine material are a good indication of how effective the regulations have been in correcting the misuse of legal amphetamines.

In his review of regulatory control of drugs in Canada, he also pointed out that approximately five years ago the Methadone Treatment Program for opiate dependency was adopted in Canada, and is currently the generally recognized chemotherapeutic method of treating such drug dependency. Approximately 1,200 persons are now receiving treatment in the methadone programs.

Dr Wilson said while the programs are under the jurisdiction of the provinces, it was necessary in June 1972 to enact regulatory changes to the Federal Narcotic Regulations that would permit a practitioner of medicine to prescribe methadone only after being so authorized by the minister of health and welfare. Before a physician receives this authorization, he is required to provide details of his proposed treatment plan including the control mechanisms which would be used, such as urine testing and supervision of dosage intake.

Alcohol affects blood-fat levels: study

By Charles Marwick

WASHINGTON — A group of American investigators has found that moderate drinking favorably affects cholesterol fractions in the blood. Cholesterol is the fatty substance implicated in major blood vessel and heart diseases.

In essence, the group has found that from four to 20 ounces a week of beverage alcohol raises the concentration of one cholesterol fraction known as the high density lipoprotein and lowers another fraction known as the low density lipoprotein. This is a biochemical picture associated with a lowered incidence of heart attacks.

The investigators, headed by Dr William P. Castelli of the National Heart, Lung, and Blood Institute's Heart Disease Epidemiology Study based on Framingham, Massachusetts, surveyed five different populations living in different parts of the United States and of different racial origin. There were more than 3,300 men and 500 women involved. The groups were in Albany, NY; two in Framingham, Mass; Honolulu; and San Francisco.

They found non-drinkers had lower high density lipoproteins than did those who drank between 10 and 19 ounces of alcohol weekly. Likewise, the low density lipoprotein fraction of cholesterol was high among the non-drinkers compared with those who drank alcohol in a similar amount.

This suggests, the investigators write in the British weekly medical journal, *The Lancet* (July 23, 1977) that moderate amounts of alcohol may favorably shift the lipoprotein balance. The presumption is this effect on lipids is a metabolic response to alcohol as alcohol is known to influence lipid metabolism and transport.

"These are challenging new findings which require considerable follow-up before they can be fully understood and before the improved understanding can be implemented," they say.

The investigators also warn that their findings "should not be taken as a prescription for altering blood fats by increasing alcohol intake."

This warning is echoed by Dr Ernest P. Noble, director of the National Institute of Alcohol Abuse and Alcoholism. He notes that alcohol is known to irritate the heart muscle and to reduce the output of blood from the heart.

"So, I would be concerned," he told **The Journal**, "about adding alcohol to the diet of an individual with known heart disease, even in the moderate amounts that this study reports."

In addition, the investigators themselves note there are ample medical and social reasons for controlling heavy alcohol intake. Quite apart from the question of whether the manipulation of blood lipids will in fact favorably affect the course of heart disease (this is not yet an established fact), the investigators add that one must be cautious in judging the medical consequences of changes in drinking habits, since alcohol has highly complex metabolic and physiologic affects.

Berlin wall no barrier to heroin traffic

LONDON — Middle east drug rings have found a foolproof way to bring huge heroin shipments into West Berlin, says *The London Sunday Times.*

The Times claims the traffickers have discovered the East German authorities will turn a blind eye to landings of the drug at the Communist-controlled East Berlin airfield at Schoenfeld.

Word has it the East Germans see the traffic as undermining the social fabric of West Berlin. So far, the unchecked flow of drugs across the Berlin Wall has caused 58 deaths in the western half of the divided city — double last year's figure.

It is easy, says *The Times*, for couriers to bring the heroin across the wall. They can use the transit bus or the inter-city underground or overground railways.

At border crossing points, the East Germans check only travellers' identity papers and their luggage. They can carry the heroin concealed on their bodies or even in their pockets without fear of detection. There are no checks on the West Berlin side because of the western principle of an "open frontier" inside Berlin.

City officials says the West German government in Bonn is planning an official appeal to the Communist leaders to stop the traffic but without much hope.

They say most of the drug-running is done by Turks, Iranians, and a sprinkling of Palestinians and Lebanese. The traffic has grown because many of West Berlin's 185,000 Turks — "guest" workers and their families — use cut-price flights to East Berlin from Ankara and can act as carriers.

The major traffic, however, is thought to be in the hands of professionals who use the Turks and others arriving at Schoenfeld as couriers or have their own import system.

Lax program directors criticized

US federal employees suffer

WASHINGTON — Many of the managers and supervisors of alcoholism programs for United States government employees have come under fire for laxness in a report compiled by the General Accounting Office.

The report says they either do not take the alcoholism programs seriously, or else they underestimate the extent of alcohol abuse among their staff.

It is estimated there are between 150,000 and 250,000 government employees who have a drinking problem. At the same time, there is a 70% success rate reported in putting employees "back into the work environment."

The GAO investigators found at one US Army base a commanding officer who assured them there was no drinking problem there. He added the civilian work force on the base "is composed of hard working people who are not under the same pressures as people in dense population areas."

An official in one government agency said his concern "is with production, not drunks."

Management officials at one US Navy base estimated only 3% of the civilian work force had a drinking problem. The head of the alcohol abuse program said the figure was from 5% to 15%.

tobacco tobacco tobacco tob

factsheet

Both the tobacco plant, *Nicotiana tabacum*, and the plant's most potent ingredient, nicotine, were named in honor of Jean Nicot, French ambassador to Portugal in the 1560s. Nicot was an ardent publicist of medical and other virtues of the herb, whose use by the native peoples of what is now Latin America had been discovered by the Portuguese nearly a century earlier. The origin of the word 'tobacco' is less clear.

Nicot's enthusiasm seems strange at a time when the use of tobacco is almost universally condemned as a major cause of ill-health. In Canada, the current annual cost of tobacco-related disability to the community is close to one billion dollars, a sum that is just a little less than the amount collected in taxes on tobacco sales. About $2.3 billion is spent in Canada each year on tobacco products, an average of about $350 for each of the country's 6.5 million smokers. Canadians have the third highest tobacco consumption in the world, after the Americans and the British. Nearly all of Canada's tobacco is grown in Ontario, where it is the most important cash crop, accounting for more than a quarter of the total crop value. More than 95% of the crop is made into cigarettes.

TOBACCO SMOKE CONSTITUENTS

Nicotine is an extremely toxic substance. Two or three drops of the pure alkaloid on the tongue will rapidly kill an adult. A 19th century Belgium, Count Bocarmé, killed his brother-in-law in this way. The fatal adult dose is about 30 mg, if administered all at once. This is less than twice the amount contained in a typical cigarette. As smoked, however, only about 1 mg from each cigarette actually reaches the blood stream. Nicotine is poorly absorbed in an acid environment such as that of the stomach. Hence, eating cigarettes is not as harmful as it might otherwise seem. The drug is readily absorbed from the lining of the mouth and from the lungs.

Nicotine is believed to be responsible for most of the short term effects of smoking, for many of the long term effects, and for the fact that tobacco smoking is such a powerful habit. Research points increasingly to the involvement of other factors — 'tar' in the case of lung cancer and bronchial disorders, carbon monoxide in the case of heart disease, and psychological factors in the case of dependence on tobacco use. Nicotine yields of cigarettes have been declining since the 1950s, largely because of the popularity of filter-tipped varieties. Carbon monoxide yields, on the other hand, seem to have increased.

Carbon monoxide is a gaseous product of incomplete combustion, best known as a poisonous emission from automobile engines. Inhaling smokers subject themselves to far higher carbon monoxide levels than could ever be achieved from inhaling the air in the busiest city street.

'Tar' is the name given to the particular matter in cigarette smoke, itself the residue of the combustion of the nearly 500 compounds that have been isolated in tobacco. Many of the constituents of tar are established carcinogens. At the rate of about 15 mg per cigarette, an average of nearly four ounces of tar is deposited in each smoker's lungs every year. Much of it is coughed up in morning phlegm.

EFFECTS

Short term effects include an increase in heart rate, a rise in blood pressure, and a drop in skin temperature. Respiration is increased. Diarrhea and vomiting may occur. The central nervous system is stimulated, but, paradoxically, smoking may also produce relaxation in habitual users of tobacco. With repeated smoking, tolerance becomes evident to most of these acute effects, but in differing degrees.

Long term effects are mainly on the bronchopulmonary and cardiovascular systems. Smoking is now believed to be the main cause of lung cancer, although there is no question that other factors are involved. Smoking is also associated with cancers of the mouth and in the respiratory tract. Many respiratory infections, notably bronchitis and emphysema, are much more likely to occur in smokers than in non-smokers. Respiratory function tends to be impaired in smokers, and they are much more likely to suffer lung complications after surgical operations.

Smokers are much more likely than non-smokers to develop coronary heart disease, cerebrovascular disorders, and peripheral vascular disease. They are more likely than non-smokers to suffer stomach ulcers, and to have ulcers that heal slowly.

Smokers tend to be less fertile than non-smokers. Smoking women have smaller babies, many more premature births, and a greater occurrence of abortion and stillbirths. Children of smoking mothers tend to be intellectually retarded when compared with the progeny of non-smokers.

Some of these chronic effects may be the result of associated habits, eg heavy caffeine use in the case of cardiovascular disease. Others may be due not so much to smoking as to constitutional factors that predispose both smoking and the disorder. The overwhelming direction of the evidence, however, is that tobacco smoking is a major health hazard.

Many of the associations between smoking and disease do not apply to pipe and cigar smoking, probably because regular users of these forms of tobacco often do not inhale the smoke. Cigarette smokers usually inhale, and continue to do so when they switch to cigars or a pipe. Thus quitting may be a better strategy than switching.

QUITTING SMOKING

Most people who smoke more than one cigarette become habitual smokers. Three out of four current smokers wish to or have tried to stop smoking, but only one in four kicks the habit before the age of 60. Most smokers smoke throughout the day. Less than 10% can limit themselves to intermittent or occasional smoking. Those who quit generally achieve health levels of non-smokers after a few years, especially if they are young. There seems to be no particular advantage to quitting past the age of 65, although many old people do give up cigarettes, possibly for economic reasons. Most successful quitters put on weight. If the weight gain is 15 lb or more the health advantages of quitting may be lost.

There is no generally effective cure for smoking. Attending a well-recommended smokers' clinic may be the best strategy. Often heavy smokers find they can halve their daily consumption merely by keeping an hour-by-hour record of cigarettes smoked. Such a reduction might pave the way to complete abstinence, which is likely to be achieved only in an environment where nobody else smokes.

WHO USES TOBACCO?

Smokers compose 45% of Canadians over the age of 14. The proportion is considerably higher in Quebec and slightly lower in the other provinces. Nearly all smoke cigarettes, and most get through the best part of a pack a day. Almost 10% of smokers use more than 25 cigarettes a day; the proportion of heavy smokers increases with age.

Overall, the proportion of smokers is declining, but this is happening largely because adult men are giving up the habit. More women are smoking, especially teenagers and women in their 50s. Although relatively fewer people are smoking than were eight years ago, those that smoke are consuming more, about 10% more than in 1968. Average consumption by smokers is now close to 20 cigarettes per day.

Smokers tend to use other drugs heavily, mostly alcohol or caffeine, or both. Smokers may metabolize many prescribed and other drugs more quickly than non-smokers, producing a significant reduction in the effects of certain drugs. This should be taken into account when dose levels are being considered.

The causes of smoking are unclear, although it is certain that teenagers are more likely to smoke if parents, family, and friends smoke. Among Canadians 15-to-19-years old, about 32% of males and about 28% of females smoke regularly, ie everyday. The proportion of males has fallen slightly during the last decade, while that of female teenagers has risen by nearly a third. Average consumption by teenagers seems to be considerably lower than that of other smokers.

TOBACCO AND THE LAW

In Canada, possession or use of tobacco products in a public place by a person under 16 years of age is an offense under the Tobacco Restraint Act. The maximum penalty on first conviction is a reprimand; on second conviction it is a fine of $1; and on third and subsequent convictions the maximum fine is $4. Police are obliged to confiscate the smoking materials.

In Ontario, it is also an offense under the Minors' Protection Act to supply tobacco in any form to a person under 18 years of age (except where the minor is on an errand for parents or guardians and bears a written request from them). The maximum penalty for giving tobacco to a minor is currently $50. Similar legislation may exist in other provinces.

NON-SMOKERS' RIGHTS

There is no evidence that a tobacco-smoke filled environment is bad for the health of healthy non-smokers, except possibly children. The smoke can be extremely irritating, however, and it may cause distressing symptoms in allergic people or in those already affected by heart or lung disease. Laws and regulations restricting the use of tobacco in public places are being introduced and implemented across Canada with remarkably little controversy. Arizona, USA, appears to provide the model for the anti-smoking lobby. Smoking in public places in that state is forbidden except where there is a notice to the contrary.

The Journal

This page is presented as a service to our readers. The text of the above is available in a smaller format, and can be obtained for minimal cost from: The Marketing Department, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Clip out this page

New Books

by RON HALL

Psychodrama: Rehearsal for Living

. . . by Adaline Starr

This book is primarily a manual on the use of psychodrama for those who want to apply this technique in a clinical or school setting. Procedures and methods for a variety of applications, including alcoholism and drug abuse, are covered in separate chapters by case history diagnosis, running commentaries on the psychodrama script, and through textual explanations. In the chapter devoted to alcoholism, the author states that the goal of therapy is to raise the lowered self-esteem of the alcoholic. Through acting out of relationships the alcoholic recognizes alternate patterns of behavior. The chapter dealing with drug abuse provides an account of psychodrama on a residential treatment unit with heroin-addicted males, and although there was no evaluation, the author has noted the value of the interaction of the professional staff with the ex-addict counsellors. An overall account of the art of psychodrama is provided in this book which combines theory and application.

(Nelson-Hall Inc, Publishers, 325 W. Jackson Blvd, Chicago, Illinois, 60606. 1977. 392p. $18.)

Summary Of The Cost-Benefit Study Results For Navy Alcoholism Rehabilitation Programs

. . . by R. B. Borthwick

This report summarizes the results of the cost-benefit studies carried out for the United States Department of the Navy's (DoN) Alcoholism Prevention Program. This work focuses on the effects of the resident treatment programs on replacement, hospitalization, accidents, jurisprudence, and productivity aspects of Navy and Marine Corps operations. Aggregated economic costs and losses due to alcohol abuse in the DoN are estimated and presented. The report concludes that the existing resident treatment efforts for alcoholics are highly cost effective and in the best interests of the Navy and Marine Corps. Further, it states continued efforts toward alcoholism prevention and earlier identification of alcoholics are warranted.

(Navy Alcoholism Prevention Program, Bureau of Naval Personnel, Washington, DC, 20370, 1977. 37p.)

Other Books

Adverse Effects of Environmental Chemicals and Psychotropic Drugs. Volume 2: Neurophysiological And Behavioral Tests — Horvath, Milan (ed). Elsevier Scientific Publishing Company, New York, 1976. 334p. $34.20.

Drugs And Politics — Rock, Paul E. (ed). Transaction Books, New Brunswick, 1977. History of narcotic use and legislation, Marijuana Tax Act, police, methadone, streets status, and drug use. 331p. $12.95.

Drug Abuse: A Criminal Justice Primer — Wicks, Robert J., and Platt, Jerome J. Glencoe Press, Beverly Hills, 1977. Drug use and abuse, alcohol, barbiturates, tranquillizers, inhalants, opiates, cannabis, halluncinogens, stimulants, treatment, enforcement and prevention. 148p. $6.95.

Alcohol, Tobacco and Drugs: Their Use And Abuse — Worick, W., Wayne, and Schaller, Warren E. Prentice-Hall, Inc, Englewood Cliffs, 1977. Social implications, theories on drug dependence, alcohol, smoking and health, drug use, abuse countermeasures. 170p. $7.95.

The Marijuana Maze — Pascal, Harold. Alba Books, Canfield, 1976. Use and abuse, the media, the law, physical and social effects, psychological effects, decriminalization. 113p. $1.79.

Identification Procedures Of Drugs Of Abuse — Choulis, Nicholas H. European Press, Ghent, 1977. Stimulants, depressants, narcotics, hallucinogens, street samples. 459p. $10.

Psychopharmacology In The Practice Of Medicine — Jarvik, Murray E. (ed). Appleton-Century-Crofts, New York, 1977. Overview, experimental psychopharmacology; clinical psychopharmacology, drugs of dependence. 553p. $25.85.

Advances In Behavioral Pharmacology, Volume 1, 1977 — Thompson, Travis, and Dews, Peter B. (eds). Academic Press, New York, 1977. Pharmacology of the tetrahydrocannabinols, ethanol self-administration, stimulus properties of drugs, effects of amphetamines, historical aspects, index, 267p. $10.

McGill study asks:

Are cocktails relaxing?

MONTREAL — Do a few cocktails really relax the social imbiber?

Amos Zeichner, a McGill University researcher, is trying to find out. The first phase of the study, begun last May, will be completed this fall.

"We would like to find out whether, in fact, alleged changes take place. For instance, does the social drinker actually experience decreased irritability," Mr Zeichner told **The Journal.**

In the laboratory experiment volunteer social drinkers (defined loosely as "somone who drinks regularly to a maximum of eight beers daily but is not an alcoholic") must complete questionnaires about various facets of drinking in daily life.

They are given three screwdrivers to drink within a specified time, with the timing and amount of alcohol geared to body weight. Any change in heart rate is noted and breath tests are administered to determine the blood alcohol level. Other data are collected on the basis of performance in the lab.

Mr Zeichner, a graduate student in McGill's department of psychology, is studying only male reactions at present. Women will have their chance for free drinks later. In all, 300 male subjects are to be evaluated, aged between 18 and 35 years, with no history of arrest or alcoholism treatment.

"Phase Two of the experiment with the female subjects may not be just a replication of Phase One. This has not been determined yet," he said.

Another breath test is administered when the session is over to ensure the subject is in fit condition to find his way home. If not, he may stay at McGill for a while. He is not permitted to bring his car.

The response to his request for volunteers to drink screwdrivers "on the house?" It was "overwhelming," said Mr Zeichner.

Protecting tots

NASHVILLE — A US pediatrician says alcohol should be treated as a poison when used around young children.

Many parents and doctors fail to realize the danger of alcohol with the very young, William Altemeier told a group of pediatricians here.

"Alcohol is a special danger to young children because it tends to cause hypoglycemia," said Dr Altemeier, director of pediatric service at Nashville General Hospital.

"The brain needs blood sugar to function," he explained, "so if it drops for long enough, brain damage and retardation will occur.

"Children under 10 years would be most susceptible to this condition. Just one beer could affect the intelligence and motor areas of the brain, with disastrous results."

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Fetal Alcohol Syndrome

Subject Heading: Women and Alcohol.

Details: 13 minutes, 16 mm, color, sound.

Synopsis: Research shows many children of mothers who have been excessive drinkers prior to or during pregnancy suffer from the fetal alcohol syndrome. The children are physically smaller than average; may lack physical coordination, and may be mentally retarded. Film cautions women that excessive drinking during pregnancy can result in irreparable damage to their child.

Accuracy: Acceptable

General Evaluation: Very good (4.8). Contemporary, informative and interesting with a clear message and a suitable length for most education uses. An effective teaching aid. Could produce attitudes opposed to alcohol use.

Recommended Use: Audiences of 15 years and beyond. Particularly useful to women of child bearing age.

It's Only Booze

Subject heading: Youth and Alcohol

Details: 28 minutes, 16 mm, color, sound

Synopsis: Alcohol problems among young people are becoming more prevalent. April, who is 13-years-old has a drinking problem, and asks what adult society is going to do about it. She talks about the social influences to drink — such as peer pressure, advertising, and adult models. April pleads with the adult community and parents to help young people with this problem.

General Evaluation: Good (4.0)

Recommended Use: Audiences of 15 years of age and over, especially beneficial to parents and teachers.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

14th annual general meeting of the Traffic Injury Research Foundation of Canada — Nov 1, 1977, Toronto, Ontario. Information: TIRF, 1765 St Laurent Boulevard, Ottawa, Ont, K1G 3V4

20th annual Scientific Assembly of the College of Family Physicians of Canada — Nov 14-17, 1977, Banff, Alberta. Information: The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9

Detox Workers Training Program — Nov 28-Dec 2, 1977, Toronto, Ontario. Information: Diane Hobbs, Coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario.

21st annual Toc Alpha Christmas Conference — Dec 27-30, 1977, Don Mills, Ontario. Information: Toc Alpha, Suite 603, 15 Gervais Drive, Don Mills, Ont, M3C 1Y8.

United States

National Conference on Medical Education in Alcohol and Drug Abuse — Nov 5-6, 1977, Washington, DC. Information: Career-Teacher Training Center, Downstate Medical Center, 450 Clarkson Avenue, Box 32, Brooklyn, New York, 11203.

1st International Action Conference on Substance Abuse — Nov 9-13, 1977, Phoenix, Arizona. Information: Vic Pawlak, conference chairperson, PO Box 5115, Phoenix, AZ, 85010.

2nd Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC — 78, 200 Broadway, Seattle, Wash, 98122.

International Arctic Rim Conference on Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

(US) National Council on Alcoholism annual forum — April 27-May 3, 1978, St. Louis, Missouri. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Joint Conference of the American Association for Automotive Medicine and 7th International Association for Accident and Traffic Medicine — July 10-15, 1978. Ann Arbor, Michigan. Information: AAAM Executive Secretary, PO Box 222, Morton Grove, Illinois, 60053.

Abroad

Asian Seminar on Research and Epidemiology on Drug Dependence — Nov, 1977, Chiang Mai, Thailand. Information: Professor Prasop Ratankorn, director, Drug Dependence Research and Prevention Centre, 268 Rama 6, Phyathai, Bangkok 4, Thailand.

3rd Arab International Conference on Alcoholism and Drug Abuse — Dec 3-7, 1977, Khartoum, Sudan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th Colombo Plan Consultative Committee Meeting — Dec, 1977. Information: The Columbo Plan Bureau, 12 Melbourne Avenue, Colombo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

International Conference on Alcoholism and Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: ICAA, Lausanne, Switzerland.

8th International Institute on the Prevention and Treatment of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

24th International Institute on the Prevention and Treatment of Alcoholism — June 25-30, 1978, Zurich, Switzerland.

TCs and psychiatry 'need each other'

MONTREAL — Therapeutic communities in the addiction field, and psychiatry, need each other, according to Joyce Lowinson associate professor of psychiatry, Einstein College of Medicine, New York.

"When a client comes into the therapeutic community initially, it is vitally important that he or she have a professional mental health evaluation. Confrontation techniques are not well-tolerated by many borderline cases," she told **The Journal** in an interview.

The fact clients entering TCs do not always have psychiatric evaluations mitigates against the TCs: borderline cases, who may be doomed to failure, become a part of negative outcome statistics, said Dr Lowinson who operates a methadone program.

"Psychiatrists could also play an important role in TCs in developing prognostic criteria. Obviously, the psychiatrist is well trained to predict which type of TC would fit a particular client.

"On the other hand, people who run TCs are also beginning to recognize they need the experienced psychiatric view in determining limits to be set. The so-called 'marathon group,' for instance, may easily get out of hand. Everyone has a breaking point."

She said group leaders must be skilled in orchestrating the nuances of verbal and non-verbal communication in group situations.

"That is not to say the group leader should be a psychiatrist. The non-professional often has a natural talent or has made himself knowledgeable. Nonetheless, psychiatric supervision would be valuable.

"The role model is important in this group situation and, in this regard, the allied health professional — or whatever you wish to call him or her — has the possibility of playing an even more critical role than the psychiatrist since there is a greater possibility of identification with the ex-addict counsellor."

The subject of psychiatry in relation to TCs arose several times during the second world conference of Therapeutic Communities here.

Monsignor William O'Brien, chairman of the TC section of the International Council on Alcohol and Addictions, and president of Daytop Village Inc, told a press conference that as far as treatment of the addict is concerned, psychiatry has been found to be counter-productive.

"The character disorders are better treated within the therapeutic community and the future of the TCs should hold more diversification so their scope will include such problem areas as acting out adolescents, first-time offenders, and parolees.

Dr Robert L. Dupont, director of the United States National Institute on Drug Abuse also discussed psychiatry.

"I am convinced behavioral medicine, which helps people to change their lifestyles to augment health and well-being, is the way of the future for social services and health care problems.

"Non-degreed professionals and paraprofessionals — persons who have experienced the same behavioral change themselves and can respond to the patient with tough-minded understanding — must be at the core of effective behavioral medicine," said Dr DuPont.

But a psychiatrist whose experience in TCs adds up to some seven years, Charles Rohrs of New York University and Bellevue Hospital, suggested the problems of the psychiatrist in the TC should be better understood. In fact, he said there is "a tremendous superficiality" of understanding of the other side in both camps.

"I would suggest that less than 1% of psychiatrists in the US have experience or involvement with the TCs."

One reason for this is the issues that confront the psychiatrist and the issues that confront the TC worker are different, he said.

Also, the psychiatrist coming to the TC brings a prior set of ideas, attitudes and expectations about what is going to take place, and the same is true of TC workers' attitudes to psychiatry.

"Psychiatrists traditionally have looked to the 'medical model' in the treatment of drug problems and a chemical solution (methadone)," said Dr Rohrs.

"The alcohol and drug abuse fields have never been well served by psychiatry and psychiatrists have pretty well abdicated any meaningful role in these areas, so involvement now comes secondarily — really by being invited back.

"Also, the TCs have functioned very successfully for almost 20 years without any involvement from psychiatry and TCs are convinced they don't need psychiatry. They don't want psychiatry and there is some justification for this in terms of how they see the problem."

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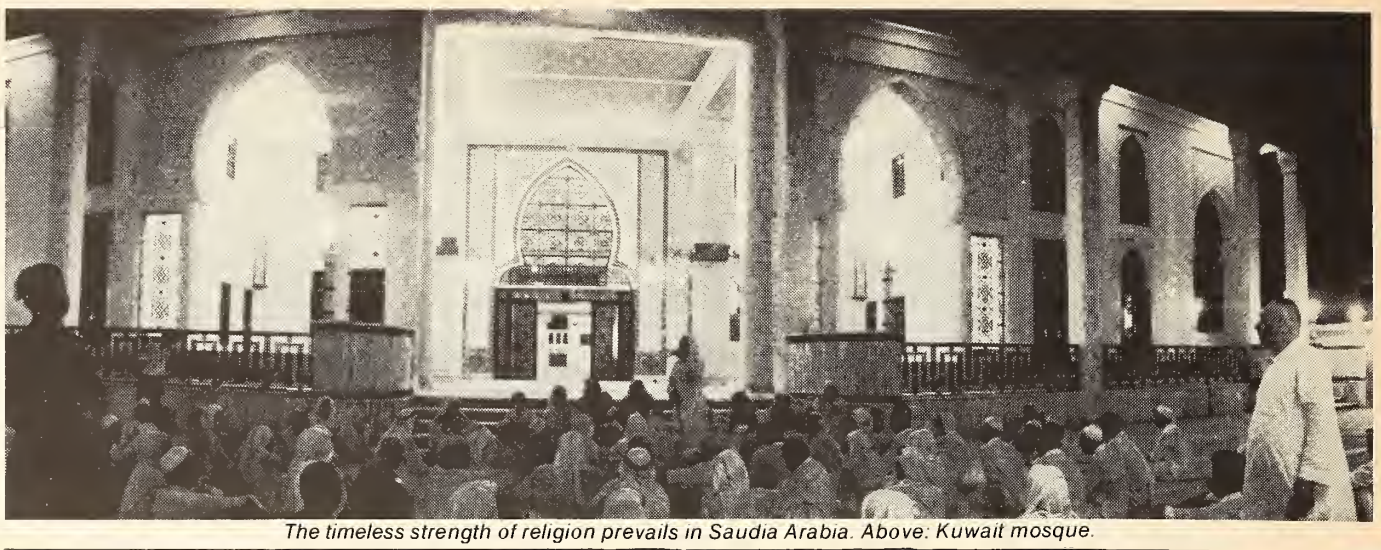
The acme of shame in Arabia



The timeless strength of religion prevails in Saudia Arabia. Above: Kuwait mosque.

Alcohol's invasion of the world of Islam

By Peter Wood*

IT'S THURSDAY evening, the beginning of the Moslem sabbath.

In a large villa in Saudi Arabia's capital, Riyadh, a group of Western expatriate workers while away the hours consuming each other's home-brewed alcohol. There is little else to do in the middle of the desert.

On the eastern shore of the country, planes take off hour after hour, crowded with Saudis and expatriates, for the 10-minute flight to the island of Bahrain. It, and Iraq, are the only Arab states in the Persian Gulf where alcohol is available without restrictions.

Some 3,000 miles to the north, in London, many Arabs on holiday spend an evening drinking openly.

A common link that leads to all the drinking is the fabulous wealth Middle Eastern oil brings.

The oil exporting companies and the construction consortia bring in needed foreign workers to a land where conditions, literally, lead many to drink.

Oil revenues are transforming the Arab states into modern industrialized countries. This material progress brings in its wake bootlegging, drinking, and, increasingly, the acme of shame for an Arab family — alcoholism.

Private clinics in London, the favorite venue among Arabs for medical treatment abroad, are receiving a rising number of Arab patients from the Gulf suffering from alcohol problems.

Saudi Arabia is the richest of all the oil nations, and the most puritanical. Publicly, it follows to the letter the strict Muslim laws completely banning alcohol.

Any Saudi caught drinking in the open is given a public flogging. Foreigners discovered smuggling in alcohol, risk immediate deportation.

But alcohol is available. Many Westerners spend much time and energy in making their own wine and liquor. As long as they drink their concoctions behind closed doors, the authorities do not appear to mind.

Most of the expatriates work six days a week and on the seventh drink. "There are only two things you can do here — work and drink," says John, an architect.

There are no movie houses or golf courses, and only a few weekly television programs in English.

The most popular drink is *sidiki* (Arabic for friend), which is made from the basics: water, sugar, and yeast. It is cheap, simple to make, and forms the staple party drink — sid and tonic.

Grape juice sells well in the supermarkets because it's easy to convert into drinkable wine. Some enthusiasts recently started buying large quantities of honey to make the mediaeval drink, mead.

Wine-making specialists like Fritz, a surveyor, will use rice and other ingredients to make wine.

Most of the ingredients for homemade beer have to be brought into Saudi Arabia. Customs officials, fortunately, have not yet recognized the tinned wort, hops, and other items for what they are.

Demand for *sidiki* is growing at such a rate that a large part of the market is being taken over by specialist freelance manufacturers. It is also a spare time business for many Westerners who distil large quantities of it in backrooms and sell it for $10 a large bottle. There are even unofficial *sidiki* makers in the compounds of many Western companies.

Drinking also plays a vital role in expatriate life in Kuwait, Iran, Iraq, and other Persian Gulf states.

The ports, airports, highways, hospitals, power stations, factories, and petrochemical plants are being built at a frantic pace with the oil revenues. Most of the highly-skilled professional labor comes from abroad, attracted by the high salaries.

There is little on which to spend the money. Social amenities and leisure facilities are way down the list of priorities for a people who only a few years ago were eking a miserable living out of the desert.

There is evidence that many Westerners who may have overcome a previous drinking problem, succumb to the situation and once again make alcohol their main outlet. People who have never had any difficulty with alcohol may find themselves becoming dependent on it for the first time. Alcoholics Anonymous groups are being formed in several of the countries.

A man receives a flogging in Saudi Arabia. His offence was drinking.

In Teheran, where alcohol is freely available, an AA group advertises itself every day in the social columns of the main English language newspaper.

One of the newest AA groups is in the emirate of Dubai, where hotels are allowed to sell drinks and foreigners who have a permit may buy alcohol from special stores.

However, to avoid attracting attention in a country where drinking is still condemned officially, the group is called the Dubai Clocktower Group, after one of Dubai city's main landmarks.

Some of the Clocktower members work offshore on the oil rigs on the 25-5 routine: 25 days on the rigs and then five days ashore. For many of the men, it is five days of drinking. Dubai too has little to offer in the way of entertainment.

Wives of expatriate workers are also having drinking problems, a result of several unusual pressures.

Social and religious customs in the countries of the Arabian Peninsula dictate that women should confine themselves to the home, and Western women are expected to spend most of their time indoors. They are not even allowed to drive an automobile in Saudi Arabia.

"Most of the wives out here are highly intelligent, well educated women, and inevitably they get bored out of their minds," says a Western woman doctor working in the emirate of Abu Dhabi.

Often, the pressures become so intolerable that wives simply walk out of their houses and fly home. The overall divorce rate is high among the expatriates.

Although it is less obvious, drinking is becoming more and more a problem among Arabs as well.

Iran and Iraq have long had established Christian minorities, and alcohol is not an alien feature of life. It is in countries like Saudi Arabia, until recently one of the most isolated in the world, that drinking has become a new and strange vice accompanying the sudden leap into 20th century industrialized society.

Alcohol is given a heightened attraction among a population already under extreme stress of rapid social change.

Rich Arabs who become alcoholic can be sent to London for treatment. For the less well off, drinking is such a taboo there is little hope of receiving treatment at home where even the development of facilities for the mentally ill is at an embryonic stage.

Though it is at the moment on a small scale, bootlegging liquor for wealthy Saudis has become an organized business.

Scotch is the most popular drink, and it is smuggled over the northern border in trucks from Levant countries like The Lebanon and Syria, and sold to middlemen. They, in turn, sell it to the private customer for $60-$70 a bottle.

The bootleg trade is so secret that no expatriate has been able to penetrate it, and only the Saudis can buy.

Some of the more Westernized Saudis are brave enough to offer a glass to a foreigner they can trust. "They are extremely generous with it. You always tend to get a glassful," a Western diplomat observes.

At times, the illegal scotch finds its way into the lower income groups. In the souk in Jeddah, on Saudi Arabia's Red Sea coast, storekeepers have spices, beans, and other goods on display in the distinctively shaped Johnny Walker brand bottles.

The weekend exodus of Saudis to Bahrain has now reached a point where notorious drinking sprees have given them a bad reputation on the island. Plans to build a causeway between Bahrain and the mainland met with some opposition initially because of fears of hordes of Saudis coming across to escape prohibition at home.

The Saudis mean big business for Bahrain's hotels. When the location of the Bahrini end of the causeway was announced a few weeks ago, hoteliers rushed to buy land near the exit point.

Saudi adherence officially to the strict religious code means alcohol will permanently be damned as highly immoral.

The ultimate disgrace is not the act of drinking, however, but to be caught drunk in public. No wealthy Saudi can allow himself to be seen drunk, even in his own home, by anyone outside his immediate family.

The manager of a Western company points out: "No foreigner can dare have a drunk Saudi on his premises.

"Once a Saudi came into my office obviously the worse for drink. I ordered him to be taken outside the company compound immediately. The whole company would have been implicated if he had been caught."

Alcoholism brings deep shame to a family. It is worse than a disease, more like a criminal offence. Alcoholics can become permanent social outcasts.

The richer families can cover up for an alcoholic relative and send him abroad. The less wealthy family has to suffer.

In other states in the Gulf, the stigma of drunkenness is not as damaging as in Saudi Arabia. Any businessman is accustomed to seeing intoxicated residents propping up the hotel bars.

As long as drunkenness is kept off the streets, some countries have been prepared to tolerate drinking among the population.

In Kuwait, for example, liquor is smuggled in on a large scale, although authorities have decided now to clamp down on some of the big operators.

The police on occasion will announce proudly to the press they have intercepted a consignment of liquor worth several million dollars. They have ceremoniously dumped it miles out at sea.

Such announcement are an indication of Kuwait's passive acceptance that drinking, though banned, goes on. If the police broke up a bootlegging ring in Saudi Arabia, the public would never know anything about it.

Kuwait customs officials are not outraged when they find bottles of alcohol hidden in the suitcases of foreigners. Instead, they usually place an unofficial limit on the numbers of bottles that may be brought in.

Some expatriate residents are known to have struck up a private agreement with officials which allows them to import scotch by the case.

Some countries are taking major steps in the decision to stamp out drinking among the resident population.

In Abu Dhabi, for example, ruler Sheikh Zayed has expressed openly his concern about the increase in drinking. Liquor has been banned in restaurants and wine is now served in tea pots.

Taxi drivers pick up drunks from outside hotels and take them straight to the police stations, reputedly in exchange for a reward.

The expatriate found drunk will be deported immediately. The resident who is found drunk faces a long term in prison.

** Peter Wood is a British journalist who travels widely in the Middle East. Because of Arab sensitivity on the subject of alcohol, he uses a pseudonym.*

THE BACK PAGE

The Journal

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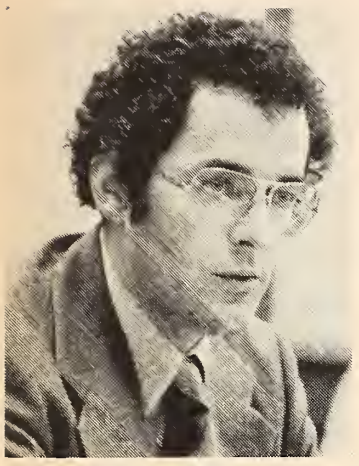


Francis Fox

There's not even consensus on a definition

Diversion zeal may prove expensive

By John Shaughnessy

QUEBEC — Current enthusiasm for diversion programs and other options to the criminal justice system could create more problems than it solves.

Francis Fox, Canada's Solicitor General, says everyone involved in the criminal justice system feels a responsibility to develop "an attitude of restraint in the use of the criminal law."

But he warned about 400 social workers, judges, police, probation officers, paroles officials, and legal draftsmen attending a conference on diversion here that in defending the principle of moderation, "we must be careful not to set up a parallel system, one which could be just as cumbersome and costly as the one we are criticizing.

"We must make sure we do not awaken in five or 10 years to find we have created an enormous machine with more people than ever subject to social and legal controls and treatments of all sorts — all in the name of humanizing the system."

Diversion programs dealing with juveniles, alcohol and drug offenders, and adults committing minor offences have been functioning informally for years, said Mr Fox. "What is new and important is the move to structure diversion and set standards for it. We now find ourselves in a situation where the number of diversion programs is multiplying even before we have reached a consensus on the definition of the term itself. And we must remember that diversion is a

(See — Diversion — page 2)

Diversion programs are generally considered better than prison for rehabilitating alcohol and drug abusers. But, in Canada, squabbles between various levels of government over jurisdiction and responsibility seriously hamper the development and long term assesment of such options. John Shaughnessy comments on the theory and practice of Canadian diversion programs on page 8.

Alcoholic workers enter a 'new era'

By Karin Pargas

NEW YORK — Half of the American work force will be covered by occupational alcoholism programs by 1983, according to Ernest Noble, director of the National Institute on Alcohol Abuse and Alcoholism.

Dr Noble told the annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism that NIAAA regards the development of occupational alcoholism programs of central importance "to our common efforts to conquer alcoholism problems."

"Some feel that goal is too high, but in a democracy, ideas must be energized by people. The 1983 goal is a test of our will and conscience as a nation.

"There is a significant shift taking place in our society's values, including those of corporate executives," Dr Noble said. "We are moving away from materialistic values, status goals, and unqualified growth for growth's sake, and moving towards humanistic values, spiritual concerns, community goals, and the quality of life.

"It is for each of us to ponder what shape this new consciousness will take, but one point seems clear . . . I see a growing acceptance of occupational alcoholism programs, not just because they are good business, but because they are good for people."

Dr Noble said Americans are already into an era that some have begun to call the caring society.'

"The moment is arriving when the 10 million Americans with alcohol problems are to be recognized as an aggrieved lot. They are discriminated against in jobs, and in health care. They are neglected in their needs, and they have been subject to dehumanizing attitudes of scorn, ridicule, and condescension."

Dr Noble said while federal funds are in short supply, it doesn't mean they are "insufficient." Federal funds that are available will be used as "catalysts" to unlock the resources of labor, management, and the health care field to encourage them to apply themselves to the development of occupational alcoholism programming.

"Unions need to find even better ways to foster programs through joint mechanisms with management. Management needs to know how to develop programs that meet the particular needs of different kinds of employees in different kinds of industries, and to develope cooperative mechanisms with unions in establishing programs."

Dr Noble said several NIAAA grants to organized labor are "laying the foundation for labor, management, and health care providers to get involved in occupational alcoholism programs on

(See — Industry — page 7)

ODAP was more than a letterhead

A brief promise of reason withers

By Karin Pargas

PHOENIX — Americans should forget realistic drug abuse management policies following the "reorganization" of President Jimmy Carter's Office of Drug Abuse Policy (ODAP) headed by Peter Bourne.

Paul E. Robinson, director of the Boston Mayor's Office Coordinating Council on Drug Abuse told the 1st International Action Conference on Substance Abuse here: "All of the promising beginnings this (Carter) administration has made appear to have been sacrificed to a bureaucratic holdover from the past administration, the all-powerful budget analyst (Office of Management and Budget). The mechanism through which we were promised national leadership and sound policy making, ODAP, is being reorganized out of existence" (See **The Journal**, Aug, Sept).

Mr Robinson said those involved in local government, particularly representatives of large urban areas with heavy concentrations of drug users seeking treatment, "have the prospect of a return, following a brief romantic infatuation with a well-constructed management activity, to the days of do-your-own thing, predatory funding, and bureaucratic infighting.

More next month from the 1st International Action Conference on Substance Abuse

"We can forget those early words from the President promising a coherent federal policy and response. It won't happen without a vehicle, or without someone in the driver's seat."

Mr Robinson said with the "demise of ODAP on the horizon, we will see a continuation of uncoordinated agency activity: the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA); enforcement and prosecution goal-setting without regard to treatment census impact or ramifications on alternative drugs of choice; attempts to secure vocational and educational rehabilitation without support from the department of labor or Office of Education."

There will also continue to be antagonism from the department of commerce for attempting to establish the recovered substance abuser as a handicapped minority entitled to affirmative action protections; and finally, no one central figure in the federal structure willing, or empowered, to referee and resolve these issues, he said.

Mr Robinson compared the reorganization of ODAP to the administrations of former US presidents Nixon and Ford — a drug policy of "political rhetoric" and "officially sponsored scare tactics."

"The Nixon and Ford administrations decided the only votes available through the drug issue were those responsive to a law and order theme, and enforcement agencies were required to shoulder more than their fair share of the drug control effort.

Paul Robinson

"Dollars and resources were shunted to a dizzying succession of federal enforcement agencies, at a time when treatment and rehabilitation funds were clearly inadequate for the demand for services in all modalities. Education and prevention monies practically dropped from sight on the federal budget, though a few key legislators lobbied without success for their restoration."

Mr Robinson said people in the US were understandably confused by the time ODAP was formed, and enforcement officials were frustrated from "having been conned" by law and order politicians that they could, if only provided with sufficient manpower and technology, eliminate drug abuse.

"More than a token executive office letterhead, ODAP offered the promise of a high-level policy-making instrument, and a means of requiring coordinated treatment and enforcement goals and objectives . . . a reasoned development of a truly national policy addressing the misuse of all substances.

"We had a promising start, orchestrated by some knowledgeable and accountable people who guided our frayed psyches through the transition period, and assured us this country could conduct a rational, balanced drug abuse management policy. We are suddenly informed this is over, and any future treatment is to be resumed under the old modality of the previous eight years. It didn't work then, I don't see why we should expect it now.

"This administration has offered some genuine international objectives for multilateral consideration. But, the concerns of whether we are spreading ourselves too thin will have to be voiced in the context of an executive level agency which has the attention of all drug abuse-

(See — US — page 7)

Next month

The first of a series of special reports from South America by Harvey McConnell, The Journal's contributing editor in Washington. Mr McConnell will be investigating drug use, production, and trafficking in Peru, Colombia, and Bolivia.

Inside

Ontario will re-set legal drinking age

TORONTO —The Ontario government will reverse a six-year-old policy and raise the province's legal drinking age to either 19 or 20 years from 18.

In mid-November a private member's bill to raise the legal drinking age to 19 was approved in principle by a vote of 72 to 29 on second reading in the Ontario legislature. Ontario Premier, William Davis, decided to let the bill die on the order paper rather than allow it to go to third reading. (In Ontario a bill must go through three readings before it can be passed into law.)

But Mr Davis also said the government would move "by resolution and/or legislation next February to crack down on young drinkers." According to the premier, the crackdown will include a stricter enforcement of liquor laws, tougher measures against people selling liquor to minors, and more stringent guidelines for liquor advertising.

"Raising the age is not by itself going to solve what I perceive to be a significant social problem," said Mr Davis. "One must take into consideration matters that are related to the whole question." Mr Davis did not cast a vote on the private member's bill because he did not want to influence the vote of other Conservatives. But he said later if he had been a private member, rather than the party leader, he would have voted in favor of the bill in principle.

In 1971, the Ontario government passed the Age of Majority Act, reducing the minimum age at which people can drink, vote, hold elective office, and enter into financial contracts to 18 from 21.

Liberal leader, Stuart Smith, who voted against the new bill, said anyone old enough to vote should also be allowed to drink. Stephen Lewis, leader of the New Democratic Party, voted in favor of the bill. He said his party's policy is that the drinking age should remain at 18, but he instinctively accepts the argument that drinking should be removed from the high schools.

Mr Davis said the issue will probably be referred to the legislature's standing committee on social development to allow "an opportunity for young people in the province, whose rights are being affected, to contribute their view to members in this House.

"I think it will take two, three, or four weeks from when it is first introduced in the legislature next February for the higher drinking age to become law," he said.

The government is studying plans to make some form of identification mandatory for young drinkers — a photo on a driver's licence or a separate identification card — to make it more difficult for minors to buy alcohol. Other concerns are whether 18-year-olds should be allowed to work in bars after the age is raised, the whole question of enforcing the age provision, and how much alcohol advertisements should be curbed.

During the debate on the private member's bill, only one member of the House spoke against raising the drinking age.

Michael Davison (NDP, Hamilton Centre) cited a study published last year by the Addiction Research Foundation of Ontario "which indicated 85% of high school students drink, although only 25% were 18 or older." (An age minimum of 19 would make it illegal for 97% of high school students to drink.)

"From that study and my own experience, I can only conclude that the bill is much more likely to have the effect of criminalizing an activity that will continue to go on, rather than removing liquor from the hands of students," said Mr Davison.

Robert Eaton (PC, Middlesex) said some minors will continue to get alcohol illegally after the drinking age is raised, "but I assure you the incidents will be much, much fewer."

William Davis

UK drug patterns may be changing

By Alan Massam

LONDON — The number of known narcotic addicts in the United Kingdom at the end of last year was 1,881 — four percent fewer than the 1,953 known at the end of 1975.

But these figures, just issued by the Home Office here, may only reflect changing patterns of drug misuse as recent drug advisory committee reports have emphasized.

The Home Office figures, for example, show that the 20.7 kg of heroin seized by law enforcement agencies during 1976 was much greater than seizures in previous years, suggesting an increase in the illicit supply of heroin.

The Home Office statistics also show that the commonest age group for UK registered narcotics addicts now is 25-28 whereas in the year ended December 31, 1975 it was 24-26. This change continues a trend of recent years. In 1972 the commonest age group for narcotics addicts was 22-24.

Of the total number of addicts recorded at December 31, 1976, 69% were being prescribed methadone alone and a further 9% were being prescribed methadone and heroin.

The Home Office further records that there were 11,800 seizures of controlled drugs during 1976, 11% more than in 1975, but 83% of these involved cannabis. The quantity of cocaine seized remained high (11.7 kg.), but the amount of opium seized was relatively low (3.1 kg.).

The number of people found guilty of offences involving controlled drugs in 1976 was 12,482, an increase of 8% over 1975, but most of this was attributed to an increase in cannabis offences and amphetamine offences. The number of people found guilty of drug trafficking offences continued to increase, the report adds.

Government should provide policies, mechanisms

Diversion needs private sector help

(from page 1)

second option, coming into play where prevention has not worked."

In his formal address, Mr Fox did not specifically mention programs to divert alcoholics and drug abusers, and a pre-arranged interview with **The Journal** on this topic was cancelled when the controversy over alleged illegal activities by the RCMP flared up in Ottawa.

However, in his general discussion of diversion programs, he emphasized that in order to protect society better and to be able to deal effectively with the real criminal element, "we must look for ways to cut the rate of entry into the system of offenders who could well pay their debt to society while remaining in the community."

He noted that the overburdening of the criminal justice system could be seen to be due both to people's belief that it is up to government to take charge and handle all problems, and to governments themselves, which for a long time have left the impression that with better control and more financial resources these problems could and would be solved.

"Diversion cannot survive unless society, through the private sector, assumes a major share of the responsibility and receives from the government the support required to do this in the form of the necessary policies and mechanisms."

Mr Fox said he is not convinced the unofficial discretionary system which has always existed and all interaction between the police, prosecutors, and the accused must be regulated. But he does believe certain formal diversion programs, based upon well-established standards and having concrete programs of providing redress, could prove to be of considerable assistance to the judicial system.

Diversion should not apply in the case of major offences, but should be reserved for those which do not threaten the order of our society, in Mr Fox's view. Further there is no question of working towards the elimination of our adversary system.

'The criminal justice system is too rigid, too overworked, and rapidly becoming prohibitively expensive. . .'

"And at this stage, while the philosophy and operational principles of diversion are becoming clearer, the relative worth of the things being tried still remains to be established. Three types of intervention —counselling, educational programs, and mediation — are being used in pilot projects" sponsored by Mr Fox's department, but "it is still too early to draw conclusions about their effectiveness".

A statement from federal justice minister Ron Basford, which was read earlier in the meeting, indicated the next omnibus Criminal Code amending bill will provide for community work orders, restitution, and other options to fines and jail terms.

The statement, read by Deputy Justice minister, Roger Tassé, said legislative guidelines would be presented to deal with community work orders now being used as part of probation orders in some parts of Canada.

Such orders are effective said Mr Basford, but there has to be protection for the offender. The community work order must not be seen as a cheap source of labor, nor as some form of slavery. Proposed legislation would require the consent of the offender.

Mr Basford described the criminal justice system as too rigid, overworked, and rapidly becoming prohibitively expensive. Courts and prisons in some parts of the country are congested, he said.

"What we must look for are flexible , more humane, and less costly ways of dealing with offenders, especially minor offenders."

Surplusplusplusplusplusmeaningmeaningmeani

By Wayne Howell

Someone reading this column regularly might easily develop the impression that I am a reactionary who wants to preserve the English language in the aspic of convention, since like some aging lexicological harpy I tend to rail against the use of social science neologisms such as 'non-dysfunction' and the dressing up of ordinary words to give them a scientific aura — i.e. using "methodology" when "method" would suffice.

Every now and then, however, I am intrigued by a new expression that describes something that has not been described before. "Rip-off" was such an expression, since until it came along there was no work to cover the middle ground between "larceny" and "cheat". "Rip-off" covered that ground nicely and filled a hole in our philological firmament.

Expressions that name things heretofore unnamed are always welcome: that is why I am quite taken by the term "surplus meaning" as it was used by NIDA director, Robert DuPont, recently.

According to Dr DuPont, the scientific community's acquiescence to the decriminalization of marijuana has had "surplus meaning". He meant that the public perceived this failure to protest as an acceptance of the view that marijuana is an innocuous drug. Dr DuPont was so concerned about the amount of "surplus meaning" generated that he entertained serious doubts about the wisdom of ever having mentioned decriminalization in the first place.

Now Dr DuPont could just as easily have said the scientific community's failure to lobby against decriminalization led to "unwarranted inferences" or "erroneous assumptions" or some such thing. But the trouble with these expressions is that they are value judgements — they imply that there is a right response and a wrong response. The beauty (and the utility) of the expression "surplus meaning" coined by Dr DuPont is that it dispenses with the rightness or wrongness of the response, and concentrates on the response as a phenomenon in its own right — surplus meaning as an inevitable byproduct of the reactions that occur between scientists, politicians, media, and public.

One can think of surplus meaning as a sort of intellectual exhaust gas that arises spontaneously out of smouldering public issues and pollutes the air surrounding those issues, not unlike the way the surplus products of hydrocarbon combustion pollute the air over our cities.

Like smog, surplus meaning tends to cloud the horizon. This explains why there are those who perceive any attempt to decriminalize marijuana as tantamount to condoning and encouraging moral degeneracy, while there are others (squinting through the same clouds of surplus meaning) who see the pursuit of decriminalization as the equivalent of the pursuit of the Holy Grail.

In fact, marijuana is such a potent source of surplus meaning that there are legislators who won't even touch the subject with the political equivalent of a 10-foot pole — a 10-man committee with vague terms of reference.

Alcohol issues, however, are almost as volatile and the surplus meaning generated can be considerable. For example, the whole argument re the pros and cons of controlled drinking as a therapeutic goal does not centre around the experiments themselves so much as it centres around the surplus meaning generated by the experiments; to wit, will the admission by some scientists that controlled drinking can work generate so much "surplus meaning" that great numbers of former alcoholics will tumble off the wagon of total abstinence, with disastrous results?

Another example: elaborate the theory that moderate drinking can lower the incidence of arteriosclerotic heart disease and you had better be ready to don a gas mask — fogs of surplus meaning will soon envelope the whole issue, making everyone concerned red-eyed, testy, and irritable, like the citizens of Los Angeles suffering through a thermal inversion.

(Wayne Howell is an Ottawa physician and freelance writer.)

Realism essential in judging diversion success

By John Shaughnessy

QUEBEC — People running diversion programs for drug and alcohol abusers are not dealing with a population of "boy scouts and virgins".

And it's extremely important to make this clear to funding agencies and various segments of the criminal justice system, says John P. Bellassai, project director of the Narcotics Pretrial Diversion Project of the District of Columbia Superior Court.

Mr Bellassai said that among heroin abusers who have gone through the Washington outpatient program since its inception in 1973, there has been a 29% recidivism rate, defined in terms of convictions. The recidivism rate for a group of controls who did not go through the program was about 10% to 12% higher.

"Some prosecutors and others in the city think our recidivism rate is much too high, but we're running an out-patient diversion program for heroin addicts. It's very unrealistic to demand the same kind of success as you would with a non-addict first offender who is diverted after having stolen something and has minor problems of social adjustment.

"If you get into alcohol and drug diversion programs you have to use multiple measures of success — social adjustment, changes in drug use, ability to hold a job, re-establishing of family ties, etc."

Mr Bellassai also noted that, contrary to the expectations of some planners and policy makers, young first offenders in addict diversion programs are not easier to deal with than hard core addicts.

"It's a difficult point to sell to the criminal justice authorities, and there hasn't been a great deal of research on it, but my impression is that if we'd had more high risk, hard core addicts in our program, our success would have been greater than it has been.

"For young people, the diversion program is often their first experience with the criminal justice system, and their experience with drugs may be relatively short. These people are not prepared to listen to the lessons from more experienced people as to what they are getting into."

'For young people, the diversion program is often their first experience with the criminal justice system...'

At the conference here on Diversion: A Canadian Concept and Practice, Mr Bellassai explained how his Narcotics Pretrial Diversion project works. The project accepts adult drug abusers (marijuana users are ineligible) who are normally heroin addicts charged with non-violent misdemeanor offences and having no prior felony convictions.

Project staff, who are court employees, screen for eligible candidates at the time of arraignment (initial court appearance) on the basis of charge, record, and indications of drug abuse.

Before being admitted to the diversion program, the person charged must, at the insistence of the prosecutor, enter an initial conditional plea of guilty. Upon satisfactory participation in the program for a stated period of time, the person charged may withdraw this plea in favor of a plea of not guilty. Successful completion of the program results in a *nolle prosequi* (no prosecution) of pending charges, while failure to cooperate with the program, or re-arrest while in the program, results in a return to court for imposition of sentence.

Treatment for those in the 10-month program includes both medical therapy and counselling. Methadone maintenance, methadone detoxification, or abstinence is available through a cooperative program with the Narcotics Treatment Administration. High intensity individual counselling is provided, as is group and family counselling, remedial education, job development and placement services, assistance with food stamps, housing and medicare."

At all "critical stages" in the program, the person charged with the offence must be represented by counsel. These stages include the enrolment decision conference, the signing of the enrolment contract, and any hearings dealing with potential dismissal from the program.

Mr Bellassai said most divertees have been young (average age is 24 years), from minority groups — mainly black, high school drop-outs, underemployed or unemployed, and about half have been first offenders.

Approximately 60% successfully completed the program during its first three years, and in his opinion, the comparative recidivism rates for graduates, failures, and "similarly-situated non-enrollees" has been favorable.

Federal-provincial seesaw

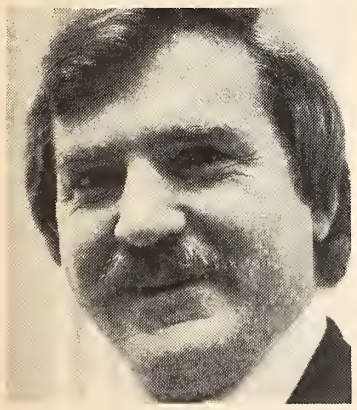
Funding problems major obstacle to diversion

QUEBEC — Funding problems are a major obstacle to the effective operation of diversion programs in Canada.

And the problem is complicated by the division of powers and responsibilities between the federal government and various branches of provincial governments.

According to Richard Anthony, senior crown attorney in the Attorney General's Office, Victoria, British Columbia, money seems to be readily available from various government agencies to set up and run short-term experimental diversion projects.

But, once the experiments are complete and judged a success, neither the federal nor provincial governments seem willing to commit themselves to long term financial support, Mr Anthony told a session on alcohol and drug diversion programs at a meeting here called Diversion: A Canadian Concept and Practice.



John Devlin

John Devlin, director general of Le Portage, a therapeutic community which runs an addict diversion program in Montreal, graphically illustrated some of the problems outlined by Mr Anthony.

Mr Devlin said his program has been in operation for more than three years and, in conjunction with the Montreal courts, has handled about 600 addict offenders. The program receives an "in kind" contribution from the probation service of office space, secretarial services, and telephones, but does not receive money from the federal or provincial governments to pay salaries for staff to run the project.

"I'm told by the federal government, the solicitor general's department, that it (the diversion project) is provincial jurisdiction," said Mr Devlin.

"But I'm told by the provincial ministry of justice that it's not a criminal justice matter, it's more for the ministry of health since we're dealing with addicts. The ministry of health says we're really operating out of the courthouse so it's part of the judiciary rather than a health matter.

"This has been going on for two years now, and unless something changes, I just don't know how much longer we'll be able to continue the project."

Mr Devlin readily admitted his project, as it operates, is a "coercion" program rather than a strictly defined "diversion" program.

"We try to work within the system and get the addict offender to seek treatment as opposed to incarceration. We run a voluntary program, but the notion of voluntaries is most questionable when the defendant's only alternative to treatment is prison."

In his view, what the Montreal project is offering is just short of compulsory treatment. The courts, under existing legislation, cannot compel any offender to enter the treatment program. But with prison or treatment the only options available, the defendant will usually exercise his prerogative of going to the treatment centre.

Mr Devlin, an ex-addict himself, said the coercive aspect of the project should not be alarming. "No addict really wants to give up his addiction. He'll say he wants treatment so he can avoid prison. Once he's in the program, it's our job to motivate him to really do something about his addiction. It's unrealistic to expect an addict offender to 'voluntarily' choose treatment if there are more attractive options available."

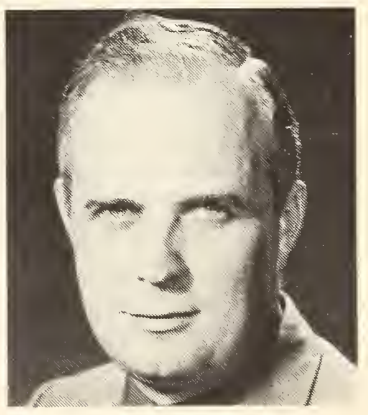
The 600 or so referrals to the Portage program from the criminal courts in the Montreal area suggest the judiciary is happy to have this option available.

Mr Devlin said the courts feel comfortable referring addict offenders to Portage because it's a long-term residential treatment centre as opposed to an ambulatory or day care type program. "The judges look at us as if we were a type of prison, even though we have no bars on our windows or the other security trappings of a jail.

"The judges also like the fact our program is a tough one. Many addict offenders have chosen to come to Portage, and then found out that it's tougher on them than jail. Every day they're confronted about their personal behavior."

In practice, the Portage program incorporates the three objectives of imprisonment — protection of society, punishment, and rehabilitation of the accused. Society is protected while the addict is in the program and especially so if he comes out of it an active and productive citizen; while in the program, the addict is punished by having his individual liberties severely curtailed and by having to adhere to the strict regulations of the house; and statistics suggest the program is effective in rehabilitating the addict offender.

If someone in the program makes a move to leave, the police and prison authorities are alerted and the person can be quickly arrested, but follow up studies indicate more than 80% of those who have completed the program are functioning positively in society without using drugs.



Richard Anthony

'We're missing the boat with women workers'

By Harvey McConnell

WASHINGTON — Signs used at work to spot male alcoholics are useless for women alcoholics because they react in an opposite manner.

"In terms of women employees we are missing the boat," according to Karen Zuckerman, women's coordinator, department of mental hygiene, division of alcoholism, New York.

The rate of referral of women for treatment is incredibly low, "and most women are just not making it this far," she told the National Council on Alcoholism's national leadership training institute on women and alcohol here.

The problem is made worse because the drinking pattern for women is telescoped and develops much more rapidly.

Ms Zuckerman pointed out the three major indicators of a drinking problem in men are lateness, absenteeism, and drop in productivity. These are not so for women.

"A woman might be late, but the problem here is that she can alibi more easily than men: she can cry, complain it is her time of the month, she has a headache, the kids are sick," she added.

As for absenteeism, "women will do almost anything to hide their problem, and as a result until they are in really bad shape, almost at the end, they will show up every day."

Ms Zuckerman said: "In general, women can con a male supervisor much more easily. And a male supervisor is not going to think of a woman as an alcoholic."

Productivity is not affected either. "As women will do almost anything to conceal their problem, they may turn out to be more productive than ever before."

A similar pattern exists in the executive realms of business. A boss will cover up for his secretary, "and she will never be confronted constructively.

"And for women executives: who is going to point the finger and say she is slipping? They would be accused of sex discrimination."

One of the most common off the job accidents for men alcoholics is an automobile accident. If a woman alcoholic is involved, often the police will escort her home, or the courts will allow her to plea bargain much more easily than a man.

Most men alcoholics would rather give up almost anything before their job, and the "shape up or ship out" threat, which generally leads to treatment, is not effective with women.

Ms Zuckerman explained: "For a married woman the loss of a job does not mean the end of the world for the family. She can return home and drink.

"A single woman will just go and find another job rather than admit to anyone else she is an alcoholic."

The ways of trying to reach the woman alcoholic must be re-evaluated. Ms Zuckerman said this can range from education of supervisory personnel, to information in pay check envelopes. Women's groups and organizations can also be a major source of help.

Pot poultice poses problem

GRAND FORKS, BC — A 77-year-old cattle rancher who uses a "pot poultice" to relieve his glaucoma has been charged with possession of marijuana.

Jack Lee insists he has never smoked marijuana. "I use it for medicinal purposes."

Last year, someone gave Mr Lee a seed but he didn't realize it was marijuana until he saw it "growing higher and higher". Mr Lee said he'd read it was good for glaucoma so he hung it up to dry in the woodshed, pulled the leaves off, minced them up a bit, and put the whole batch into a quart sealer.

"Then I cooked some up, stewed it like tea, and put a poultice on my eyes. It seemed to give me great relief."

Drinking and crime go together: Hamilton study

By Betty Lou Lee

HAMILTON— Violent crime in a neighborhood is directly related to the alcohol consumption rate in licensed premises in that area, a Hamilton study has shown.

Drinking-related aggression hits its peak as the bars close, and on weekends, and is more likely to involve physical harm.

The study, thought to be the first of its kind in Ontario, was done by Lowell W. Gerson and Donald A. Preston of the department of clinical epidemiology and biostatistics at McMaster University. It is part of a wider survey of alcohol and drug-related problems in the community, financed by grants from the Non-Medical Use of Drugs Directorate of Health and Welfare Canada.

The study showed a consistent relationship between the per capita consumption of alcohol in licensed premises, and the rate of violent crime in each of 18 districts in the Hamilton-Wentworth region.

In the highest consumption district (two gallons of absolute alcohol yearly for everyone of legal drinking age) the rate of aggressive acts known to police was 3,952 per 100,000 population. At the other end of the scale, in the district where the drinking rate was 0.27 gallons of absolute alcohol, aggressive acts were 886 per 100,000.

The team concentrated on the drinking rate in bars, taverns, and restaurants because it was the only situation where the location of actual consumption is known. Alcohol sold in retail outlets in one district may well be consumed in another.

Alcohol consumed in licensed premises accounts for 20% of the total volume of the average 2.8 gallons of absolute alcohol consumed yearly by Hamiltonians of drinking age (excluding sales at wine stores and home-made alcoholic beverages). The 215 licensed premises in the region account for 30.5% of all beer sold in the area, but only 10.6% of the liquor— more than 73% of the alcohol sold in them is beer.

Violent or aggressive crimes included in the study were homicide, assault, rape, sexual assault, and threatening behavior. Police recorded 5,178 such acts between April, 1976 and March, 1977— 10% of all the non-traffic events they recorded — and one-third of them involved alcohol. Another 5.5% of the recorded events were 2,764 violations of specific liquor statutes. "Enforcement of liquor laws plays a significant role in police activity," Dr Gerson noted.

'In marital disputes, if there was a physical assault, drinking was a factor half the time . . .'

Alcohol was involved in eight of 16 homicides, half of the marital assaults, 60% of rapes, 45% of assault involving injury, 40% of assaults on police, 20% of sexual assaults other than rape, and 34% of common assault.

When similar situations were compared, the more serious or violent one was more likely to involve alcohol. Thus in marital disputes if there was a physical assault, drinking was a factor half the time. But if there were only threats, alcohol was involved in only 28%.

Alcohol is involved in 34% of common assaults, but in only 12.7% of threatening behavior. If there is actual injury in the assault, alcohol is a factor in 45.6% of cases.

The 20% rate for indecent assault jumps to 60% for rape.

Drinking days, rather than calendar days, were used to map patterns. Wednesday, for example, would run from 4 a.m. Wednesday to 3:59 Thursday. The alcohol-related crime rate rose steadily through the week, from a low of 27.2% on Sunday to 45.5% on Friday, and 43% on Saturday. In the 10 a.m. to 4 p.m. time span, drinking was related to only 13.2% of aggression, but this jumped to 62.2% from midnight to 1 a.m. and 60% from 1 a.m. to 4 a.m.

Dr Gerson speculated that drinking habits as closing time approaches may be a factor in these rates.

"People tend to order more when it comes close to 'time' and impairment is related to the speed at which you drink. . . . This pattern may account for aggression after closing time, because it's not in or near the bars, it's in homes or elsewhere after 1 a.m."

The seasonal pattern was a peak of aggression in summer, followed by spring, autumn, and winter.

In correlating drinking to violence, the team controlled for such factors as population density, income, owner-occupied buildings, and the proportion of men and women who were 18 to 29 or over 65.

They concluded, "A clear and consistent relationship exists. The rate of alcohol consumption in licensed establishments effects the rate of crimes of violence in that district."

Teen car accidents double at legal drinking age

HAMILTON — The rate of alcohol-related traffic accidents doubles among Hamilton teenagers when they reach the legal drinking age.

In 1976, 7.1% of 18-year-old drivers involved in accidents had been drinking, compared to 3.9% of 17-year-olds. The previous year, the rate was 6.8% for 18-year-olds, and 3.2% for 17-year-olds.

Last year, 46 of the 651 18-year-old drivers in accidents had been drinking, and 19 of 484 17-year-olds.

There was also a 359% increase in the number of 16-year-olds involved in alcohol-related accidents between 1975 and 1976, but Lowell Gerson of the department of clinical epidemiology and biostatistics at McMaster University, says this should be interpreted with caution. The numbers are small and only two years of data are available. In 1975, only two of 117 16-year-olds in accidents had been drinking, or 1.7% while in 1976, the rate was 6.1% — 15 of 247 drivers.

The highest rate of alcohol-related accidents occurred in the 20 to 29-year-old group, who took over this dubious distinction in 1976 from the 30 to 39-year-olds. In both years of the study, the rate for the 20s was 7.4% but for the 30s, it dropped from 8.1% in 1975 to 6.5% in 1976. Drivers in this decade accounted for the same percentage of all accidents in both years, 17%.

Those in their 20s account for the biggest percentage of all accidents, 31%.

The overall rate of drinking drivers involved in accidents was about 6%.

Dr Gerson made the analysis of all traffic accidents in the Hamilton-Wentworth region during the two years as part of an overall study of alcohol and drug-related problems in the community financed by $240,000 from the Non-Medical Use of Drugs Directorate.

Alcohol-related accidents peaked on weekends, and just after closing time for licensed premises. Of the 3,120 accidents that occurred between 4 p.m. and 10 p.m., only 10.4% involved drinking drivers. But of the 1,521 between 10 p.m. and 4 a.m., one-third were alcohol-related.

In 1976, 27% of accidents between 10 p.m. and 1 a.m. involved alcohol, but in the three hours after closing time — 1 a.m. to 4 a.m., the rate jumped to 43.5%. From 4 a.m. Saturday to 4 a.m. Sunday, alcohol was involved in 18.5% of all accidents, but from 4 a.m. Monday to 4 a.m. Tuesday, the rate dropped to 6.6%.

He also found alcohol-related accidents tended to be more serious. In 1976, the average damage if a driver had been drinking was $1,398. If no alcohol was involved, the average was $908.

Alcohol was involved in 11.5% of fatalities, and 15% of personal injury accidents, but in only 9.4% of property damage mishaps.

Sex of the driver was noted in only 1,802 cases. Two hundred and twenty seven drivers had been drinking. Sixteen percent of the 1,300 male drivers had been drinking, but only about 5% of the 502 females.

'There's no turning back'

Feminists and women in alcohol field should unite

By Harvey McConnell

WASHINGTON—The emerging women and alcohol movement in America has made a deeply feminist and political statement, and there is no turning back, believes Ruth Abram, of the Women's Action Alliance.

She told delegates to the National Council on Alcoholism's women's national leadership training institute here there should be a coalition between the feminist movement and the women and alcohol movement.

Until now, the feminist movement "has failed to address the particular problems faced by women and alcohol," Ms Abram added.

"I believe to the extent to which we allow women to remain degraded, we allow to exist an undenied problem of the woman alcoholic."

Coalitions "only work if each and every participant feels they have something to gain. We have to ask ourselves what we have to offer organizations of women in the states and the nation."

Ms Abram said women must be helped "to feel comfortable with the idea of addressing their needs first, without feeling guilty, or selfish. Those who have struggled with alcoholism understand why it is important to work out their needs first."

Women can be offered a better understanding of their bodies, and the physical and emotional impact produced by various substances. This fits neatly within the growing women and health network.

Ms Abrams pointed out much of the funding for alcohol programs for women must come from philanthropic foundations, corporations, and individuals Their needs and actions must be understood.

Philanthropic foundations, "whose business it is to give away money to support social progress and programs, cannot do it unless there is someone to take that money and develop a response to a social problem. You must approach them with this in mind, as necessary partners.

"You are not begging, you are doing the foundation and this society a great, enormous favor, Let them know it."

Ms Abram said women face two particular problems when it comes to raising money.

"One is confidence. We fail time and again to consider ourselves winners. You must conceive a program and think of yourselves as winners, because they back who they think is going to win. They get 'Brownie' points in their community for that."

The second problem is often women go in "with an idea that is not quite baked. An idea needs to breathe and needs exposure. Until you feel you can answer all the questions, do not go to a funding source, give it a couple of more months."

Proposals must be like legal briefs, and then followed up. And, Ms Abram added, the risk of rejection must be taken "because risk is the name of the game."

Pregnant women shouldn't drink at all: panel

Curtain rising again on FAS

WASHINGTON— A recommendation that pregnant women should not drink at all has been made by a special panel set up in Wisconsin to study the fetal alcohol syndrome.

Delores Niles, who headed the panel, told the National Council on Alcoholism's national leadership training institute for women and alcoholism here that the panel was able to expand its scope and consider the whole problem of women and alcohol.

"It has proved to be a very exciting project, and now everybody seems to be getting on the bandwagon," Ms Niles said.

Until the problem of the fetal alcohol syndrome became news, and the panel was established, it had been very difficult to get most officials to recognize the special needs of women drinkers, she added.

The panel has been able to recommend that an office be established on women and alcohol, and other drug abuse, to lobby and advocate for women's needs. Funds have been requested for development of treatment facilities and programs specifically for women.

Ms Niles said the panel found in the Wisconsin state alcohol and drug abuse authority none of the 37 staff members "has any responsibility for women's needs. One of our recommendations is for a full-time doctor who will focus on the needs of women."

Ms Niles commented that during their research the panel found that what is now called the fetal alcohol syndrome was not new to medicine.

Until prohibition began in the United States after World War I, there was a lot of information in the literature about dangers of alcohol use during pregnancy, and some doctors cautioned their patients not to drink.

"With the advent of prohibition here, all conversation about the effect of alcohol on the child and woman ceased. It was as if a curtain came down," Ms Niles declared.

Research in France in the late 1940's cited many cases of babies affected by alcohol, but no attention was paid in America until recent research reports from Boston and Seattle were published.

Ms Niles said the panel has recommended a statewide public awareness campaign about the danger of drinking during pregnancy. In addition, specific programs should be aimed at women and girls. Family planning centres should have information, and advise appropriate methods of contraception for heavy drinkers who seek their services.

Special education material should be developed for the poor and minorities. This would include simplified audio-visual aids for people who cannot read.

A drinking history form should be developed and sent to doctors and hospitals throughout the state. All health professionals should be trained in recognizing the syndrome and taking necessary action.

Alcoholic wife must make her own decisions

DETROIT — A married woman alcoholic must be allowed to make her own decision on whether remaining at home is best for her.

The acceptance of this fact by many now helping women alcoholics marks the greatest advance in treatment over the past 10 years, thinks Antonia D'Angelo, head of the National Council on Alcoholism's committee on women and alcoholism.

Ms D'Angelo, who in 1966 helped establish the NCA's women and alcohol group in Philadelphia, said: "Back then, we were programming women to go back home and take care of their children and their husbands. Now there are a lot more options.

"But we are still having to train psychiatrists, particularly the older ones, to realize they don't have to program women back into this. Perhaps this is not the way they want to go, and it is not a decision for the psychiatrist or anyone else to make. It is for the woman to make."

This change in approach is still not happening all the time, and all over the country, Ms D'Angelo added in her report to the annual meeting of the Alcohol and Drug Problems Association here.

Much of the change is due to the rise of the women's movement. Ironically, while adding options, the movement has also added strains.

Ms D'Angelo explained: "The range of options also means making decisions that are frightening to many women. Many are looking for some kind of release, and substance use is one of them.

"There is a question of guilt and of whether they can do it."

There is also pressure on women "who really want to be homemakers, who really enjoy that kind of life, and get a good deal of satisfaction out of it. It is almost as if they are not allowed to do that now."

Ms D'Angelo, who has been active in the movement, takes issue with many in it, especially a number at the top level. "I have heard them say that homemaking is a reasonable way to spend your life, but there is something there in the expression and tone of voice that denies that.

"This is a transitional thing, I think. Homemaking should be one of the professions, on the same level as others."

Many women still have a problem of self-esteem when they get out into the world, and in many cases worry about rejection. This leads them to turn to alcohol.

Ms D'Angelo said she has found men are suffering as well during this transitional period. In the final analysis, for most women, "we don't want to lose the value of being female."

Ernest Macdonald

Decrim won't help chronic alcoholics

QUEBEC — The move in Canada to decriminalize public drunkenness offences will do little to improve the "unsatisfactory" treatment of chronic alcoholism.

One rationale for decriminalization is that treatment will be given instead of punishment. According to Ernest Macdonald, executive director of the Addiction Foundation of Prince Edward Island, in many cities this type of thinking has moved the police away from involvement with the public drunkenness offender.

"But very few chronic alcoholics voluntarily seek long-term treatment so the end result of decriminalization is no treatment and no punishment."

Mr Macdonald told the conference here called 'Diversion: A Canadian Concept and Practice' that an alternative system has to be set up whereby police may still be involved as a protection measure, but if necessary, diversion can begin after the offender is picked up.

"Also, if it seems necessary, the offender may be charged and committed to the care of a treatment agency for a period of six months to a year. The chronic addict may elect to serve the time in jail as an alternative to a treatment program."

In dealing with public drunkeness and chronic alcoholism, society has yet to decide whether the public drunk is a criminal, a public nuisance or is sick, said Mr Macdonald. "If he's a criminal he should be behind bars. If he's sick he should be in a hospital.

"Usually we want to get rid of unsightly people, and the system at large only wants us to get the drunk out of view. But in many cases, the public drunk is sick, is a criminal, and is a public nuisance. The police, the jailors, and the judges know this, but the problem is that we have not yet found a way to sort out who should be dealt with as a criminal, a public nuisance, or as someone needing treatment for his illness."

Mr Macdonald said that in an attempt to improve this sorting out process and to make the treatment of chronic alcoholics "less unsatisfactory", the Addiction Foundation of PEI, in conjunction with the department of the solicitor general is this month beginning a program to divert people with alcohol problems away from the criminal justice system.

The diversionary actions take place at two main points. An individual who is drunk and sick may enter the program without police involvement — he may choose to enter a special alcoholism unit rather than risk the possibility of being charged; or the police may bring in an individual without charge. If he is a repeater, he may be charged so the court, under provisions of PEI's Liquor Control Act, can order a committal to a long-term care unit.

Mr Macdonald said the special alcoholism unit and a long term care facility have been added to PEI's treatment resources specifically for the diversion project. The Special Alcoholism Unit is a 25-bed emergency centre with detoxification capabilities, but will function primarily as a 48-hour assessment and referral unit for people with alcohol problems. The long term care facility is a 15-bed residence to which people may come voluntarily or be committed by the court. The emphasis in this unit is on "humane maintenance" with farm and workshop activities.

"What we want to do is get the drunk off the streets, sober him up, and sort out what he should do or what we should do about him," said Mr Macdonald. "In order to exercise our options in a sensible way we've got to wait until the drunk sobers up. So we need detox facilities, as well as access to medical and psychiatric assessment and some motivational capability to get the person started on the job of getting help. These functions are part of or linked to the emergency reception centre."

Coordination between the police and the centre is essential to the effective operation of the program, and the long term care facility is considered crucial as a back up unit.

"We have no illusions that we have here a way to solve the problem of public drunkenness and chronic alcoholism. We only hope to make it a little less of a problem," said Mr Macdonald.

"We take the view we are dealing with a person who has taken a legal drug in amounts that are too great for his system to handle. Although he has deliberately loaded this on himself he is entitled to some protection until he sobers up. If he continues to load up time and time again to the point where we think he is out of control then we have to take over for him for a few months until he can once again control himself.

"Even if we fail to get the chronic alcoholic to achieve long term sobriety we won't feel too badly. We have to accept the fact that some individuals may have to live most of their lives in a semi-protective dry centre. It's much cheaper to have them live like this than slowly destroying themselves while they clutter up the courts, the jails and the police vans."

Skid row myths delay on-job plans

NEW YORK — The image of an alcoholic as a skid row bum is the major reason occupational alcoholism programs are not widespread in the United States today.

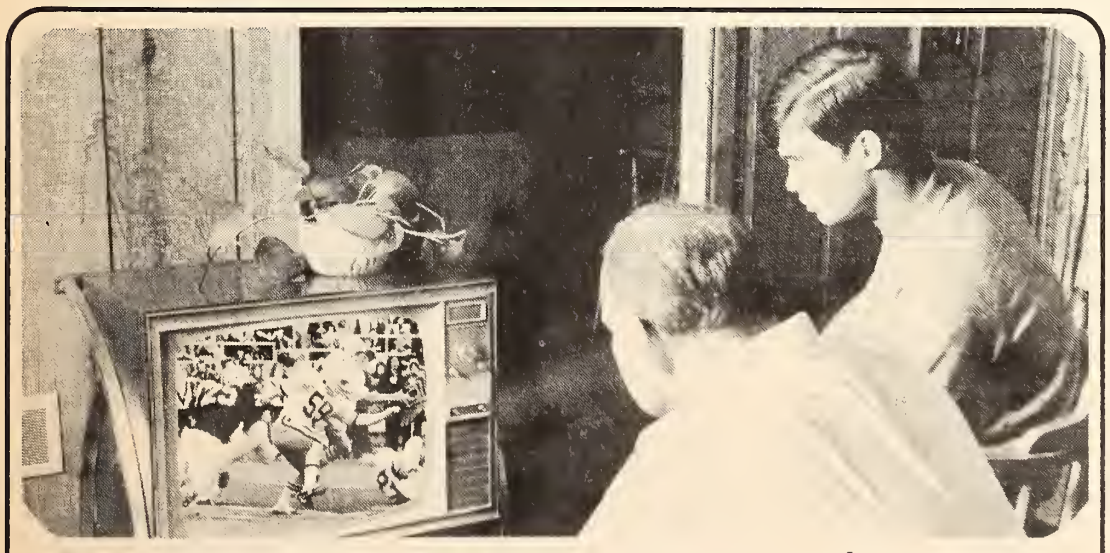
There is an urgent need for further research in occupational alcoholism to counterattack the myth of the skid row bum being the only person with a serious alcohol problem, Paul Sherman, president of the Association of Labor-Management Administrators and Consultants on Alcoholism, told the annual meeting here.

"When key people in an organization look for alcoholics, they look for the skid row bum, and it becomes easy for them to say 'we don't have much of a problem here.' In most cases, it's not that they're against an (employee assistance) program, but they give it a low priority," Dr Sherman said.

"What is needed is a broad education program aimed at top management and labor leaders to describe how alcoholism manifests itself in the workplace. This is a long term effort, and I would urge the National Institute on Alcohol Abuse and Alcoholism to consider this a priority item, added Dr Sherman who is also director of special programs for International Telephone and Telegraph.

"I will recommend to Dr Ernest Noble (director of NIAAA) that a task force including ALMACA, NIAAA, and other national organizations be established to look at research needed.

"I'm also recommending that whoever does the research must understand alcoholism. There are only a limited number of dollars — far too few — and let's ensure that the research is at this time, short term, and easily applicable," Dr Sherman concluded.



TV addicts tune in, turn on, and pay up

DETROIT — Television addiction can be an expensive habit. In one month it cost 93 Detroit-area families $500 each.

The Detroit Free Press, in an effort to study the effects of "television addiction" approached 120 families and offered them $500 to give up TV for a month. Ninety-three families refused, and only 27 said they would go along with the deal.

In a typical response, one woman said: "My husband would never do it. He comes home from work and sits down in front of the TV. He gets up twice — once to eat and once to go to bed."

The newspaper selected five families from the minority who agreed to the proposal, each having a different social and economic background, and sent in a TV repairman to disconnect their sets for a month."

Alcoholism needs 'deadly' tag

NEW YORK — Americans must be convinced alcoholism is as deadly a disease as cancer if any strides are to be made into effective treatment and prevention of alcohol abuse.

Leo Perlis, director of the AFL-CIO told the annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism: "There is a lack of perception on the part of Americans that alcoholism is not only a disease but a deadly disease. We have to show people that alcoholism does cause death to the mind and to the body, and stress how fatal a disease it it."

Mr Perlis said American national agencies like the National Council on Alcoholism, and the National Institute on Alcohol Abuse and Alcoholism aren't as effective as they could be, simply because they have a lack of funding to advance their cause.

"I'm not trying to take any money away from the Jerry Lewis Telethon for Muscular Dystrophy or the annual campaigns by the American Cancer Society," he said, "but I think the deadly disease of alcoholism should be able to raise more funds from the American people in view of morbidity and mortality rates."

He continued: "There should be only one item on the agenda of any national organization concerned with alcoholism — how can we reach the American people with the message that alcoholism is deadly?"

Mr Perlis said ALMACA should limit its own confrontations between labor and management views on occupational alcoholism programming and concentrate instead on working together to curb alcoholism.

He concluded: "The disease doesn't care whether you're upper management or a laborer; whether you're male or female, or whether you're black or white, or young or old. It doesn't care. We must all join forces in order to spearhead a new movement for a greater perception of the disease and more money to fight it."

Drugs cease to be a problem in prairie city

By Manfred Jager

WINNIPEG — Both the isolation and the harsh climate of this prairie metropolis are credited with having reduced drug addiction to such an extent that drug misuse — particularly by young people — no longer is considered a problem.

The trend, believed by experts in the field to have started about two years ago, is best reflected in the fact that, later this winter, Winnipeg's only formal methadone program is to be phased out.

Methadone clinic director, Nady Guebaly, a psychiatrist on the staff of the St Boniface hospital, said last month the number of people in the program stood at 70 several years ago and has since shrunk to less than 25, with no renewed increase anticipated.

'Supplies of hard drugs are very difficult to get in Winnipeg now . . .'

Dr Guebaly said those now receiving methadone will continue to be cared for, but the formal program will soon be ended.

Instead, said the psychiatrist, the hospital will start a day-hospital type of full-time rehabilitation program for alcoholics. That program is expected to be operational by early 1978, Dr Guebaly said.

Initially, the new unit will care for eight to 10 patients, but expansion of the program is likely as the hospital is the only institution with a medically-based alcoholism treatment service east of the Red River.

"The need for such a unit is far greater than what we are going to be providing," Dr Guebaly said.

Interviews with officials of the Alcoholism Foundation of Manitoba, the Manitoba department of health and social development, and Winnipeg police as well as with the executive director of a downtown clinc — set up almost a decade ago specifically to deal with drug abusers — all reveal one development: drugs other than alcohol have ceased to be a problem in this city of 600,000.

"We used to see two or three bad trips from LSD, amphetamines, mescaline, and MDA here every week at one time," says John Silver, executive director of Klinic, a community health centre set up when the problem was at its worst during the late 1960s and early 1970s. "We still see some people who are doing drugs, but the number is way down from the days when the situation was of sensational concern in this city."

Mr Silver says his clinic deals with about 1,300 people each month who make contact because of drug-related health or social problems. Most of them, however, merely telephone for some information, and only about 200 patients actually come in for appointments with physicians, nurse practitioners, or counsellors.

Among them, those with alcohol-related problems are in the majority.

"Many of those who call us are parents who suspect their kids use marijuana, and who want some information about this," Mr Silver said.

Inspector Paul Johnson of the Winnipeg Police Department said law enforcement agencies in the city are no longer alarmed by the level of substance abuse in the city, "although we continue to watch the situation very closely, of course, so we can stay on top of it."

Young people continue to use marijuana and some amphetamines, Inspector Johnson said. But the number of heroin addicts is down to "fewer than 50, I'd say.

"Supplies of hard drugs are very, very difficult to get in this city now. There are too many chances of getting caught when buying the stuff or when bringing it in. We made a seizure of 81 caps of heroin here just last week and that meant that the market faced a major, major problem."

Most of the heroin coming into Vancouver stays in the general area of that city now, with enough addicts in the West Coast centre alone to make sure it gets sold, Insp Johnson said.

"And as heroin supplies fail to reach as far east as Winnipeg, users by and large also avoid this city."

It is also possible, he added, that more young people are growing out of their teens in Winnipeg right now than are entering them — "and we know that delinquency tends to drop off around age 17, when people have done their experimenting and found the scene less satisfying than what had been expected. Besides, there is always the possibility of being raised to adult court when caught for an offence."

An official of the Alcoholism Foundation of Manitoba said part of the reason for the drop in drug abuse in Winnipeg is the often questionable purity of supplies.

"Too many people get scared about this, and decide not to take chances," the spokesman said.

"A lot of the stuff that arrives here from elsewhere has gone through so many hands you don't know anymore what it contains. People have heard about really bad experiences of others, and we keep hearing of youngsters who succeeded in getting themselves off drugs for that reason alone.

"As for amphetamines, which are sold in pharmacies — it's almost impossible for young people to get prescriptions now unless the physician in question is completely convinced there is no other way of treating a patient."

'Kids just can't afford to sit around and smoke pot anymore . . .'

Finally, the university drug scene has changed completely as well, the AFM spokesman said. "The economic situation across Canada is such now that kids can't afford to just sit around and smoke pot anymore. Their own situation and that of their parents demand that they get busy and hussle to get finished with their courses and graduate."

Doctors' judgement inhibited

FDA amphetamine restrictions won't curb abuse

By Harvey McConnell

WASHINGTON — Increased restrictions on amphetamine prescribing will hurt doctors more than they will help reduce stimulant abuse, believes David Smith, of San Francisco.

The Food and Drug Administration proposes to stop the use of amphetamine for obesity, and limit prescribing to cases of narcolepsy and hyperkinesis (**The Journal**, November).

Dr Smith, associate professor of toxicology at the University of California at San Francisco, and head of the Haight Ashbury Free Medical Clinic, says rescheduling of amphetamine in 1971 (from schedule 3 to schedule 2) did reduce amphetamine use to a level, and it has remained constant since.

"However, I don't think eliminating the use of amphetamine for short term treatment will have a significant impact on amphetamine abuse. People who abuse diet pills, in our experience, will just switch to other drugs, or go out and buy the illegally made 'mini-whites' off the streets."

What the proposal will do is further reduce the prescribing ability of all doctors, and impinge on their clinical judgement.

Dr Smith and colleague Donald Wesson, assistant professor of psychiatry at the University of California at San Francisco, have studied the epidemiology of amphetamine abuse for the past 12 years.

They are engaged currently, with no-string financial assistance from Smith Kline and French Laboratories, in an amphetamine evaluation and physician training project which held its first meeting here.

The nationwide study will evaluate the use of amphetamines in narcolepsy and hyperkinesis, study the pharmacology and neurochemistry of the drug, and assemble material to educate doctors on diagnosis and treatment of abusers.

At a two-day conference in San Francisco in September, 1978, Dr Smith says they hope to involve the Drug Enforcement Administration, Food and Drug Administrations, and state law enforcement officials in producing regulatory guidelines.

Videotapes of amphetamine abusers talking about their experiences will be presented to local, state, and national medical organizations. A book will also be produced.

Dr Smith says the present FDA proposals on amphetamines "has caused us a great deal of alarm. This is because the FDA, via the physicians desk reference, makes a doctor criminally liable if he deviates from prescribing indications in the PDR.

"We see the PDR as a contract between the FDA and the manufacturers of drugs, and doctors are not a party to that contract, nor bound by it. What we prefer is the American Medical Association drug evaluation, which allows for clinical judgement."

A personal example of the conflict is Dr Smith's use of phenobarbital as a withdrawal technique in the treatment of barbiturate abuse. It was devised by him and Dr Wesson, and is the recommended technique issued by the National Institute on Drug Abuse.

Dr Smith continues: "If you look in the PDR, though, it is not recommended for barbiturate abuse. This means I am potentially criminally liable about three times a week when I treat barbiturate addictions this way, and so are hundreds of physicians across the country."

Dr Smith sees the only answer in more vigorous law enforcement to catch the script doctors. This will help curb the problem of abuse, "and won't punish every physician in the United States a little bit."

Victims of alcoholics emerge at work

By Karin Pargas

NEW YORK — Industry is the biggest victim of alcoholism in the United States because it suffers a $1 billion a year "hangover" from lost productivity of workers.

However, workers who are costing their employers money because they are not producing fast enough, or well enough, are not always alcoholics.

Josie Couture, founder and president of Other Victims of Alcoholism Inc, told the annual meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism here that the domino effect of alcoholism manifests itself directly in the workplace.

"A co-worker may cover up for an alcoholic employee out of loyalty, and therefore becomes a victim. The co-worker suffers guilt and anxiety, just as the alcoholic does, and begins to act as if she or he were a member of the alcoholic's family, feeling duty-bound to cover-up again and again."

Ms Couture said the domino effect of alcoholism knocks over the alcoholic first, but then all the other dominos start to fall — hitting the spouse, the children, the grandparents, the employers, the friends, who also are parts of the work force.

"We must find these people, these victims, and try to reach them before their job performance deteriorates," she said.

"Every facility and service that has been created for the alcoholic on the job must be recreated for the other victims of alcoholism," Ms Couture said.

Karen Hoover, in-patient coordinator of Loretto Hospital's Alcohol Program and Education Center said the objective of occupational programming has been to identify problem employees and try to help them find a solution to the problem that is interfering with their job performance.

But, alcoholism affects a minimum of four other people. In some instances, if those "significant others" are employed, their own job performances become so seriously impaired they too become a problem, she said.

"Traditional health care systems may not always be sensitive to the needs of a client who wishes to stop someone else's drinking," Ms Hoover continued.

However, the industrial counsellor can find a way to deal with this "other victim" if the counsellor can accept the premise that "those involved in a significant relationship with the alcoholic often inadvertently contribute to the alcoholic's disease pathology due to ignorance of the disease, or due to reacting to immediate crisis situations that must be dealt with, in a way that might not be functional in helping the alcoholic."

Women workers aid women

WASHINGTON — A woman trained to help fellow workers with alcohol problems is now in each local branch of the Amalgamated Clothing and Textile Workers union in the United States.

Some 80% of the 500,000 members are women, and aged generally in their 40s and 50s, according to Madeline Tramm, PhD, research associate with the union.

Dr Tramm told the National Council on Alcoholism's leadership training institute on women and alcohol here, the women knowledgable about alcohol took time off without pay for special training, and are part of the social service committee in each local.

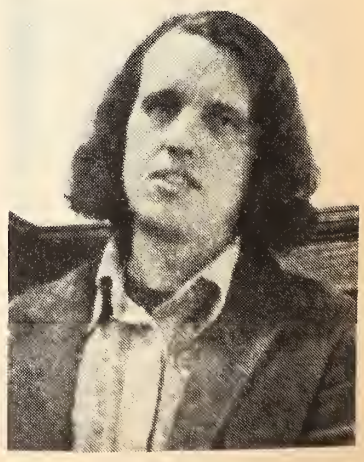
"They are also trained about the local agencies in their area so they can act as a kind of referral network," she added.

In areas where union membership is very large, social workers and psychologists have been employed to help women drinkers. Dr Tramm said: "The union provides an atmosphere of confidentiality, supportiveness, assistance, and care that other components will not."

Another area of union help is counselling of women who are nearing retirement. "We think this is very important because a drinking problem can be aggravated by the thought of retirement, or it can be hidden and come into full force then," Dr Tramm pointed out.

Union interest in problem drinking among members is pragmatic as well. Sickness and accident benefits paid out by the union for alcoholics can hurt programs in other areas, for example.

Dr Tramm added that grievances which may be related to drinking can mar management and union relations. "Unions have as vested an interest as management in programs that deal with the problem of alcoholism."



David Smith

UK launches 'sensible drinking' prototype

By Alan Massam

LONDON — Britain's health and social services secretary David Ennals has launched a major "sensible drinking" campaign in the North-east of England as a prototype for a national strategy to combat growing alcoholism.

The campaign aims to generate community action over a three-year period using all existing health and social service resources in the field and a Health Education Council grant of £175,000.

There will be an educational program to emphasize problems caused by excessive drinking; secondary prevention in the form of the mobilization of Alcoholics Anonymous and other helping agencies to cope with anticipated increased demand; and attempts at improved referral through improved liaison between psychiatric and medical services.

The North-east region covers an estimated population of 2,648,500 including Northumberland, Durham, Cleveland, Newcastle, Gateshead, Sunderland and Tyneside.

The administrative focal point of the campaign will be the offices of the North East Council on Alcoholism at Mea House, Ellison Place, Newcastle-upon-Tyne. It will be co-ordinated by the director of NECA, James Martin.

A spokesman for the Health Education Council told **The Journal** the campaign would be backed by publicity on television, radio, press, and cinema, spelling out the dangers and disadvantages of excess drinking and the strains it can place on family life and personal relationships.

"There has been a steep rise in alcohol addiction and we now estimate that 11 in every 1,000 adults has a serious drink problem, including increasing numbers of women and young people," he added.

"But well-organized health education of the public can undoubtedly help to prevent it."

For bright drop-outs with drug problems

Cool School salvages one-third of its students

By Betty Lou Lee

HAMILTON — An alternative school program that began in 1971 as a salvage operation for high school dropouts involved in drug abuse has been successful with slightly more than a third of its students.

A quarter of them have gone on to college or university and 11% either returned to regular school or got satisfactory jobs.

James Anderson, professor of anatomy at McMaster University, and Fred Ridley, coordinator of Cool School, compiled data on the 81 male and 42 females who completed the Cool School program or dropped out of it between 1971 and March, 1976. In addition to the 36% with successful outcomes, 35% showed some improvement. There was no improvement in 29%.

The authors of the assessment report noted that for a period in 1974, when Cool School was made a part of the regional adolescent services at Chedoke Hospital, some inappropriate admissions to the school, because of a temporary lack of more suitable programs, may have had a negative effect on the results.

They also noted a change in the drug orientation of students in the five years under study. Although speed abuse was common among the first students, alcohol and suicide attempts now tend to be more prominent. They see all these forms of self-abuse, however, as symptoms of the same problems:

"They have left school in boredom, disgust, or real fear of reentering an environment which they found totally unsuited to their needs.

"Many are immature in attitude if not in age, cannot accept responsibility, cannot get along with their peer group or their family. Some habitually drug themselves or drink to the point of blotting out reality. Some become entangled with the law. Some make half-hearted or sincere attempts to depart altogether from life."

Cool School was designed for bright drop-outs with university potential. Although its curriculum does not include formal lectures and structured subjects, it is a comprehensive and compressed program that stresses budgeting of time, self-reliance, development of social skills and self-esteem, and being able to work effectively either alone or with a group.

An important phase of the program is spending one week at each of eight working situations in the community, and reporting in detail on each of them to the rest of the group — a phase that often involves 70 hours a week.

Those who have gone on to university have found this method of learning has stood them in good stead. Even though they haven't the regular high school credits, they have been accepted at most Ontario universities and have "done extremely well", says Mr Ridley.

The Cool School emphasis on written work, finding or making your own teaching aids, and judicious work planning have made it easier for them to adapt to the university setting which is less controlled than traditional high schools.

Judging from the first 123 students, those most likely to do well in the Cool School program are males who enter at age 17 or older, with at least Grade 10 completed, and living at home with at least one parent.

Those referred by agencies or as a term of probation did not do well. Parental or self-referral was more usually linked to successful outcome.

The prospects for going on to university or college were best for those who had been out of school three or more years, even though eventual outcome was better in general for those who had been out of school less than six months.

"Apparently in the interval some growing-up took place. The student made a decision as to what he or she wanted to do in life, and entered with strong motivation," the authors say of the group who had been years without formal schooling.

While the original emphasis was on salvaging drug abusers with high potential, the school will now consider "any student who has major difficulties in coping with the school system." After more than a year of operating on assorted grants and donations, Cool School has been funded by the Ontario education ministry since 1972.

"Very few students were making no use of drugs whatsoever on arrival," the report says of the first 123. "One female student did not use any type of drug; another 16-year-old made mild use of alcohol only. The picture was somewhat brighter for the males, but not much. Six used no drugs at all, two made mild use of alcohol only, and one male used no psychedelic drugs but was a heavy or uncontrolled drinker.

"Serious use of intravenous drugs and of solvents (glue-sniffing and so on) was negligible. About 40% of both sexes were habitually or heavily involved with marijuana. Heavy alcohol use among the males ran over 40% also, but only three females fell into this category. Females tended also to avoid use of hallucinogens, but a quarter of the males used them heavily or habitually. In general, females using drugs or alcohol did so mildly or occasionally only, with marijuana the single exception."

Continued use of alcohol or another drug was a big factor among those who didn't complete the Cool School program. The report noted that daily use of cannabis "does not seem to produce medical problems, but it decreases the level of motivation and achievement very markedly.

"Successful adaptation to the program and a good outcome is almost totally dependent on dropping the heavy or habitual use of drugs and alcohol. With the exception of the three percent who continued to use cannabis heavily, none of those who partially completed the program and went back to school or to steady work, or progressed to college or university, continued heavy use of any drug . . . In general, with the group who has left the school, the progression has been that an initially mild user (of cannabis) becomes a non-user, and the heavy users have cut their use either down or out."

The 56% who did not use intravenous drugs when admitted to the school has grown to 76% non-users among those who have finished or quit the program.

Industry gains on alcoholism

(from page 1)

a massive scale . . . the momentum will be self-perpetuating."

"We've come a long way from the situation of seven years ago when federal legislation created a national commitment to occupational alcoholism programming. Only a few people were on those programs. Today, there are at least 1,125 professionals involved. Five years ago, few states had alcoholism programs for their employees. Today, most do. In 1971, there were only about 300 private sector programs; today they number about 1,000.

"This progress is helping to create a momentum of its own as more companies have a successful experience and show others the way."

Dr Noble pointed out the success of General Motors of Canada employee assistance program:

"Among a group of GM employees who accepted treatment for a drinking problem, sickness and accident benefit costs dropped 48%; Workmen's Compensation costs dropped 64%; and disciplinary grievance procedures went down 58%.

Conversely, Dr Noble said, among those who refused treatment, sickness and accident benefit costs climbed 128%; Workmen's Compensation costs went up 77%; and disciplinary procedures increased 33%. (see **The Journal**, April, 1976).

Dr Noble concluded: "You should have no concern that occupational alcoholism programming will be put on a backburner in Washington. Congress specifically named it as a priority concern. In the White House, President Jimmy Carter has given prevention a green light in his policy pronouncement about health care. For my part, I pledge my continued commitment and that of the NIAAA to the development of occupational alcoholism programs."

Ernest Noble

Cooperation is the key in work place

EDINBURGH — The best approach to the problem of alcoholism is a cooperative effort between employers and employees.

In fact, says the Scottish Council on Alcoholism in its 3rd annual report, the approach establishes the need for:

- A formal company statement of policy and referral procedures relating to alcoholism, agreed by both trade unions and management;
- Links between the company and qualified diagnostic and treatment services within the community;
- Extensive in-company training and educational programs.

In the foreward to the report, the executive chairman of the SCA, Lord Minto, says the period 1976-77 saw the first signs in Scotland of a "desire to cooperate" between management and unions. They were both seeking to resolve the chaos of alcoholism within industry and "prepared and anxious to listen."

The report says the cultural heavy use of alcohol before, during, and after work in Scotland is now costing an estimated £100 million annually. It says the absence of agreed policies and procedures for identifying and helping the alcoholic contributed to the denial of the problem—helping neither the company nor the employee.

"All the available evidence indicates the prevalence of alcoholism is greater the higher up the management ladder one climbs, and that alcoholism does not differentiate between manual and clerical workers," the report goes on.

"To resolve these problems, a joint union-management approach to alcoholism recovery is advocated since neither party can accomplish maximum results unilaterally.

"A joint approach minimizes the ability of the alcoholic to manipulate the alcoholism problem into a controversy between management and union representatives."

Liquor bottle warning to women

WASHINGTON — Every bottle of spirits should carry a label warning women they should not drink if they are pregnant, in the opinion of Donald Kennedy, head of the US Food and Drug Administration.

A present, the FDA cannot order such a label because power lies with the US Treasury Department.

Dr Kennedy said action should be taken to change this, and the treasury will be asked to issue a label "because the evidence is clear" of damage to the fetus from heavy drinking in pregnancy.

Dr Kennedy said he would also like to see warnings on the possible side effects of drugs printed on the side of the package, starting with tranquillizers. Tranquillizers represent 7% of all prescribed drugs.

He added: "We believe doctor-patient relations will be improved if patients know more about drugs."

Dr Kennedy said such actions as he suggests are needed as one way of controlling America's runaway medical costs, by prevention of disease.

US needs drug leadership

(from page 1)

oriented activities, foreign and domestic, demand reduction, and supply reduction.

"A sharing of various international priorities and enforcement concerns is long overdue, but if this is to be balanced with domestic efforts, this administration must make a high-level commitment to staff and prestige. The Office of Management and Budget is an unlikely reservoir for such support."

Mr Robinson concluded: "Until appropriate leadership occurs on a permanent basis on the federal level to ensure efficient coordination of drug abuse activities, efforts on the local level will remain restrictive and passive . . . and this is a matter of concern to all people, whether from the United States or other countries.

"Effective international collaboration and balanced domestic coordination will require a central, professional, decision-making mechanism. This body, representing every phase of the drug abuse field, has the right to make this demand."

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Letters to the Editor

'I'm co-alcoholic'

I am married to an alcoholic, and in terms of the disease, I am called the co-alcoholic.

For most of my life, I had a picture in my mind of the typical alcoholic; a skid row bum lying in a gutter. However, all walks of life, rich or poor, black or white, male or female, young or old, can be a victim of the disease. No one asked to have cancer, nor did anyone ask to be an alcoholic.

I am very concerned about the alcoholic, and his or her disease, but I am also concerned about the family of the alcoholic.

The affected and afflicted family of the alcoholic can receive help. I am receiving such help.

I was on the verge of insanity when I finally found Al-Anon. Al-Anon is an anonymous organization designed for the family, friend, or relative of an alcoholic. Al-Anon points the way for a normal, useful life.

Al-Anon opened many doors to recovery for me and my children. Al-Anon led me into a whole network of help. Through Al-Anon, I found Concerned Persons, a program offered by the Division of Alcoholic Services here, to provide education on alcoholism, and to generate an awareness of one's own feelings.

I feel a great need to let others know there is help, and there is hope. No one has to live their life in despair.

Mrs Bonnie Closter
Richmond, Virginia

Marijuana

I read with interest Ross J. McLennan's letter in the October issue of **The Journal**. Mr McLennan is rather well known in Oklahoma for his conservative stands with respect to alcohol/marijuana issues. His neo-prohibitionism has a certain sentimental charm.

However, he should be reminded that his state is far above the national average in the number of its citizens incarcerated for marijuana offences. The state stands under court order to immediately reduce its prison population due to inhumane conditions, and for several months has stoutly resisted compliance. If Mr McLennan, as he says, has "yet to discover anything vital or substantial to build (a) case ... for decriminalizing," he should have.

Richard Wilson,
Fort Supply, Oklahoma.

Pot coverage 'paranoid'

Every presenter at M-DART's three day Symposium on Marijuana had one major message: cannabis is far more than an innocuous weed. The warnings and danger signals were most significant.

Yet, your Harvey McConnell, reporter, in a perfect example of paranoid advocacy journalism, (**The Journal**, Oct.) writes that cannabinoids produce no mutations, hence no cancer, a subject that Dr Zimmerman did not discuss at all during his participation in the conference.

This "coverage" of our symposium was expected but not appreciated.

Alfred V. Miliman, JD
Director
Maryland Drug Abuse Research and Treatment Foundation, Inc.
Baltimore, MD 3005

Roller coaster world

May I take this opportunity to thank **The Journal**, and in particular John Shaughnessy, for your October issue story, Alberta — A Roller Coaster World.

We found the article very well written and perceive it as a great asset in informing the rest of Canada that, as Mr Shaughnessy pointed out, Alberta is not a "new utopia" and suffers the ills of alcoholism at an alarming level, something which, unfortunately, not enough Albertans realize. Therefore, may we request of **The Journal** to have 500 reprints of this article to distribute to a number of our legislators and other parties in our province.

A. G. Wright
Director
Public Affairs Division
Alberta Alcoholism and Drug Abuse Commission
Edmonton, Alberta T5K 1L9

Women's issues column

I am just writing to let you know how I feel about **The Journal**. I can only tell you that I am most impressed with the general layout, the quality of the articles, and the scope which they cover. I also look forward to the *New Books* column and the *Factsheet*.

My one request/concern would be that I would like to see a regular column on women's issues. There are new developments, as well as ongoing research, and new programs occuring all the time with respect to women and their addictions. As such, I think there would be ample opportunity and information to include a monthly column.

Wishing you success with **The Journal!**

Gail Walsh
Executive Director
Conato Incorporated
Bathurst, New Brunswick

'I think it's about conserving energy — Mom wants only the Christmas tree to get lit up this year.'

Comment

Passin

By John Shaughnessy

"Look," he said, "I had a kid who was raising hell at school — when he was there. And I had an old man who was living by himself, hitting the bottle hard and getting depressed because the high-rises going up in his neighbourhood were driving the birds away.

"I got the kid to go and see the old man, just to see him, and the next thing I knew the two of them were working together building a birdhouse.

"To me that's diversion."

The tall unkempt man in his mid-twenties who told this story was sitting in the Quebec airport obviously anxious to get home and back to work after three days of discussions on Diversion: A Canadian Concept and Practice at a meeting sponsored by the ministry of the solicitor general and the federal department of justice.

He had come to the meeting to give a presentation, and to learn something. He gave the presentation, but he had serious doubts about the value of anything he had learned. The meeting, he said, was a waste of time.

The young man was not alone in his opinion. From the speaker's podium, in the corridors, over lunch, delegates were wondering aloud about what was going on and why they were there. A crown attorney said: "We've spent all kinds of time playing with definitions of diversion, but no one's talking about how we can get the money to run the programs."

The director of a diversion project for addict offenders made the off hand comment that the money spent on background materials for the meeting could finance his program for a year, and he's not getting a dime from the federal or provincial governments.

A probation officer stated flatly that to get anything done, the people running diversion programs have to work together and ignore squabbles between the federal and provincial governments over jurisdictions and responsibilities.

Admittedly our governments, like ourselves, have to live with our constitution. Until it is changed, the British North America Act, under Section 91.27 gives the federal government exclusive jurisdiction over criminal matters, and gives the provinces, under section 92.13, exclusive jurisdiction over property and civil rights, which includes health, education, and most social assistance matters.

But diversion, by its very nature, calls for cooperation and is antithetical to this strict division of powers and responsibilities. As Francis Fox, Canada's solicitor general, said at the meeting, the offender begins in the criminal justice system and is referred to a community resource. Diversion, he n survive unless the pri assumes a major share of sibility and receives supp government in the form policies and mechanisms.

What he did not say was vate sector may also need support in the form of mon

The problem here is that of powers provides gover planners with a ready-mad for passing the buck. Otta admit that prison is too co more harm than good for n and drug addict offende provinces are skeptical that lightened views may mean prison will become the pro cial responsibility as a mat health or welfare.

Meanwhile, as the exper tage Inc. indicates (see program operators run fro government to another in a to get some money from so things now stand, any gov agree in principle to a diver and in the same breath financial responsibility of s

When a government has cial responsibility, its co diversion tends to sag. P Narcotics Control Act, whi

Guest Opinion

Employee assistance—Canada has problems

Alcoholism and other occupational health problems are common in all parts of the industrial world. Although the problems are international in scope, potential solutions are often unavailable or limited by specific laws of the country in which they are tried. **The Journal** *is publishing the following guest opinion so our readers can better understand that programs and problems in one country cannot necessarily be assessed on the basis of criteria from another and that experts in the field cannot simply transplant successful programs from one country to another. — The editor.*

By Garry L. Briggs, PhD

Occupational behavioral health programs in Canada are different from those in the United States, because:

• Canadian union members and other Canadian workers do not have a constitution which ensures them certain "inherent" rights and protects these rights from unscrupulous politicians.

• Canadian workers do not have legislation which protects information gathered about their private lives, and ensures them confidentiality with matters they discuss with their priest or personal physician.

The Canadian government can deny all freedom or rights to Canadian workers merely by invoking The Emergency Measures Act. The laws and system of government that affect the Canadian people are quite different from the US's system of laws and government.

It is these differences that dramatically change the face of all occupational mental health programs, occupational drug and alcohol programs, or occupational behavioral health programs, and the labor-management atmosphere in Canada.

Pro-management occupational alcohol and drug programs, because there is no federal legislation to protect confidentiality, have led to mis-use of occupational mental health, and alcohol and drug program.

Canadian workers have become deadened, or even terminated when unscrupulous personnel officers misused personal medical information and personnel information. This has caused labor relations in Canada to be very tenuous in the area of occupational mental health, or alcohol and drug programs.

It must be understood that Canadian law is brought into being through Parliament, which is controlled primarily by barristers. They have enacted laws which protect only the barrister-client relationship, as far as confidentiality is concerned. There are even recent cases where this relationship between the barrister and client has been 'bugged' by the Crown.

Guidelines published in Alberta to assist the establishment of Employee Assistance Programs (EAP) have ignored labor entirely. A few guidelines published in Canada regard labor's role as superficial, and imply that labour unions should rubber-stamp any Employee Assistance Programs that management offers them.

This has led to the establishment in Canada of Employee Assistance Programs by business, industry, or government, that interfere with the union's protection of their members. These guidelines have brought about Employee Assistance Programs which are set up by management, are management-oriented, and run for management's own end.

'The Canadian government can deny all freedom or rights to Canadian workers merely by invoking the Emergency Measures Act . . .'

The problems and mis-use of these programs have caused many within the Canadian Labor movement to counter with occupational mental health, or alcohol and drug programs that promote equality on policy development and programming.

The Alberta Union of Provincial Employees has taken a position that Canadian Employee Assistance Programs should be replaced by Worker Assistance Programs (WAP) which are neither pro-union nor pro-management, but rather pro-people. AUPE has found that the disease of alcoholism, drug addiction, or emotional illness is anti-union, anti-management, and anti-people.

Some occupational consultants in Canada, acting privately or as agents of special interest groups or government, have urged companies or unions in Canada to adopt policies regarding alcohol and drug problems in the work place that would deny a union's right to represent their members in the grievance procedure.

The union's position has been very firm — that no union should or will agree to sign away a member's rights to the grievance procedure in cases where he may be ill because of the disease of alcoholism, or other substances, and is seeking treatment and rehabilitation to arrest his illness.

'Canadian law does not recognize the doctor-patient or priest-patient relationship as beyond or above Canadian law . . .'

Canadian law does not recognize the doctor-patient or priest-penitent relationship as beyond or above the law. A priest or doctor can be imprisoned for failing to release information they have been given by a worker. Doctor's files on patients in Canada, have been seized by the police on judicial orders, photocopied, and originals returned to the doctor. Only selected barristers and the Attorney General's department know where the copies have gone.

This lack of protective legislation regarding confidentiality in Canada, has brought caution to the Canadian labor scene. Canadian unions, because of the lack of protective legislation, have encouraged their members not to give out information to management-run Employee Assistance Programs for fear that this information may be used against them in their career, and their private lives. The potential for mis-use of confidential information in Canada is very grave.

In 1970 the Conference Board of Canada published a monograph entitled, *Company Controls for Drinking Problems*. It stated that, "at all levels of management and labor, leadership must commit itself to the underlying spirit and philosophy of a constructive rehabilitation effort. If a program has the aura of a management audit rather than a jointly conceived and implemented effort, it cannot succeed. A sound alcoholic program requires the establishment of a firm understanding between labor and management, with appropriate contract language to support it; that if a worker accepts treatment, and if such treatment involves leaving the work environment as with any illness, job rights will be explicity protected."

The Alberta Union of Provincial Employees has found these guidelines to be necessary if effective control of behavioral health problems in the work place is to take place. Appropriate contract language can bring about workable Worker Assistance Programs that provide recognition, referral, treatment, rehabilitation, and follow-through — worked out, if possible, through a joint union-management program.

Where the Alberta Government, as an employer, has not been willing to enter into such a program, The Alberta Union of Provincial Employees has set up its own Workers Assistance program. The need of a Worker Assistance program by The Alberta Union of Provincial Employees has come about through the recognition that the mere reliance on the excellent fellowship of Alcoholics Anonymous and other self-help programs is not the only answer for behavioral health problems in the work place, nor is the provision of an alcoholic counsellor or medical or psychological staff within the Province.

'Careers in Alberta have been destroyed in the name of occupational alcohol and drug programs . . .'

AUPE has found the approach allocated by Canadian Employee Assistance Programs (CEAP) is not acceptable or workable in the Alberta labor scene. Instead, it has actively advocated that a new approach be set out which would be entitled Workers Assistance Program.

Canadian Employee Assistance Program (CEAP) has come to mean in Alberta a program that is: management-oriented; paternalistic; subject to employer mis-use; and philosophically part of management. The cost of the program is at the expense of the worker's rights and career; cost benefits are hidden by the employer; and occupational programs, set by the employer in his company's policy can be changed at his will.

The program in Alberta which is more acceptable to the AUPE is one called Worker Assistance Program (WAP). This program is: work-oriented; work-centered; has appropriate checks and balances against mis-use negotiated into the contract; and is philosophically responsible to the worker as a patient. The cost to the work is measurable; the cost is on a shared basis with the employer which is negotiated into the contract; and the policy is set in the negotiated contract, and can only be changed through negotiations.

In the province of Alberta, AUPE has found that unless a program is supported by appropriate contract language in the negotiated contract, it will have no relevance upon the action taken by the employer in regard to behavioral health problems (that develop in the work place). Nor will there be protection for the worker who seeks through professional avenues to correct a behavioral health problem that may have overtaken him.

Albertans do not have constitutional rights or legislation to protect workers. Careers in Alberta have been destroyed in the name of occupational alcohol and drug programs.

Alberta Union of Provincial Employees members are on guard, and sometimes may be seen as adversaries in approaching occupational behavioral health services unless they are union controlled, and/or expressly spelled out in the negotiated contract.

***Garry L. Briggs, a medical sociologist specializing in emotional problems related to work, is Director of the Member Counselling Unit, Alberta Union of Provincial Employees.**

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preventive detention and custody for treatment, was enacted by the federal government in 1961 and was to come into force "on proclamation." To date — 16 years later — no proclamation has been made.

Is it any wonder delegates to the meeting were less than enthusiastic about the federal government's apparent endorsement of the diversion concept?

To be sure, diversion programs can present problems. Experience in the United States with regard to marijuana laws suggests the presence of diversion programs can be an obstacle to decriminalization. In states where marijuana offenders are diverted, efforts to decriminalize marijuana have been minimal or have been unsuccessful. Diversion can be used as a half way house to avoid having to decide whether a law ought to be enforced or repealed.

There is also a real danger that the wholesale institution of diversion programs could result in a bureaucratic jungle larger than the criminal justice system and one which makes more people subject to more social and legal controls and treatments. In addition the current poor employment situation seriously hampers diversion programs in their efforts to re-integrate successful divertees into the job market whether or not their criminal records are expunged.

Days can be spent, as they were in Quebec, discussing whether "diversion" includes discretionary decisions by police and probation officers; whether it includes options to imprisonment in sentencing those convicted; or whether it is confined to a voluntary choice made by the offender at the post-charge but pre-trial stage.

These questions are fundamental to the establishment and evaluation of diversion programs of all sorts. But discussions of definitions, goals, and objectives lose their impact when the basic question — who is going to pay? — remains unanswered. A clearly defined and structured diversion program and a vague idea that addicts and alcoholics are not helped by being sent to prison are equally valuable or useless if the program never gets into operation because funds are not provided.

Bureaucrats and planners can spend years playing mind games with concepts. The losers in this game are the potential divertees — the alcholics and the drug addicts who continue to pass through the revolving doors of the criminal justice system while our leaders squabble over definitions, jurisdictions, and responsibilities, and keep their wallets in their pockets.

Cynically, one is inclined to suggest that, despite the rhetoric and the experimental programs, governments and the public are not particularly concerned about the rehabilitation potential in diversion unless it costs a lot less than the current practices of imprisoning chronic alcoholics and addict offenders.

It's a depressing thought, but the young man at the Quebec airport buoys my spirits. His parting comment was: "Remember my 'juvenile delinquent' and my lonely old alcoholic. When you think of diversion, think of building a birdhouse."

John Shaughnessy

International psychotropics convention

Trans-cultural studies for risk/benefit issues

By Thomas Land

GENEVA — How do you strike the right balance between the risk from the abuse of a drug against the risk of hampering, through control, its use by patients who genuinely need it?

The question arises from a new international convention on the limitations of psychotropic substances to medical purposes. An international expert committee on drug abuse, which has been charged to find the right balance, recently met in Geneva; and it sought the solution through trans-cultural studies.

The new convention supplements the Single Convention on Narcotics Drugs of 1961, dealing with substances such as opium, morphine, pethidine and cocaine — most of which have significant medical uses. Psychotropic substances which are also covered by the new convention are chemical agents capable of modifying mental activity including depressants such as barbital and methaqualone, stimulants such as amphetamines, and hallucinogens such as LSD and mescaline.

The United Nations, the International Narcotics Control Board, the International Council on Alcoholism and Addictions, and the International Criminal Police Organization all took part in the UN World Health Organization's first expert meeting here which called for trans-cultural studies to allow drug abuse information to be controlled and digested in a uniform manner. The meeting also urged the WHO to establish or to strengthen existing mechanisms for assessing the public health problems arising from the abuse of psychotropic substances and to help in the development of new methods to collect relevant data.

Among the public health problems created by psychotropic substances when abused, explains a WHO spokesman, are serum hepatitis, infections and septicemia from use of non-sterile injection methods, physical disabilities resulting from vehicular and other accidents, death due to overdose and mixing of psychotropic drugs with other substances, non-specific health disorders resulting from neglect of personal hygiene and improper nutrition, possible precipitation of mental disorders and toxic psychoses from use of certain psychotropic drugs, tissue damage including damage to the central nervous system from direct effects of these drugs or overdosage, and damage to the fetus.

Prediction of the likelihood of abuse, and the risks involved in the abuse of psychotropic substances involves four steps. The first is the culmination of pharmacological and toxicological data, mostly in animals and, to a certain extent, in man; and the extent of such studies in man might vary considerably depending on the nature of the drug. The second is judgment of the dependence potential in man based on these data. The third step is prediction of the likelihood that the substance would be abused by certain individuals within a society or culture; and the fourth is prediction of the risk to both the individual and society when the substance is abused.

All these factors and assumptions will need to be considered in the limitation of psychotropic substances for medical purposes. In addition, a spokesman for the group said, the effects of psychotropic substances may be influenced even by environmental and social factors. For instance, temperature, size and nature of habitat have been shown to modify both the intensity and the duration of various stimulatory or depressant phenomena.

Drug evaluation, as required by the new convention, will be thus a cumbersome and expensive job but also an essential one in view of the high potency of psychotropic substances.

Germany's drug problems growing

By John Dornberg

BONN — Alcohol and drug abuse are on the increase in West Germany, according to Antje Huber, the minister of health.

Replying to a query from the opposition Christian Democrats during a parliamentary question period recently, Ms Huber said the number of West Germans endangered by alcohol continues to increase.

She reported that approximately 4% of the country's population over the age of 14 are involved — 1.5 million people — of whom 10% are "in acute need of treatment."

According to the health ministry, anyone who consumed more than 100 grams of alcohol — 2.5 liters of beer, a liter of wine or 12 to 15 shots of spirits — daily must be considered as endangered.

There is a pronounced trend in increasing alcohol abuse from the lower to the middle and higher income groups, she said. In addition, the health ministry has noted marked regional differences in alcohol consumption and abuse.

Surprisingly, the lowest percentage of those endangered by alcohol — 2% — is to be found in the North German states of Schleswig-Holstein, Lower-Saxony and Northrhine-Westphalia where the drinking preference is for high-proof clear spirits, in particular the various kinds of schnaps.

Conversely, the highest percentage of alcoholics and endangered adults — 8% of the total population — is to be found in Bavaria, a traditional beer-drinking area, followed by Baden-Wuerttemberg where the preference is for both wine and beer.

Bavarian beer generally has a higher alcohol content — 5% — than that brewed elsewhere in Germany. In addition the state's northern region — Franconia — is a major wine-producing area.

Baden-Wuerttemberg has two major wine areas: a 60-mile radius around the state's capital, Stuttgart, and the Middle Rhine from Baden-Baden upstream to the Swiss border — across the river from Alsace Lorraine. Though the wines from these regions are not as well known abroad, large quantities are produced and drunk locally.

Although rising alcohol consumption as such should not be viewed as alarming, said Ms Huber, "it is irresponsibility" on the part of 25% of all parents when they pour alcoholic beverages for their children under the age of 10 on holidays and festive family occasions. More than 41% have no objections to their children taking an occasional "sip."

Touching on the drug problem, she stated that the number of drug-related offenses in West Germany had increased by 16% from 1975 to 1976 to a total of 37,989 cases in that year.

The number of cases of smuggling and illicit traffic in drugs rose by 17.5% to 15,023 during the same period.

(The Federal Criminal Office in Wiesbaden reported that there had been another 10% increase in the number of known addicts and drug-related crimes during the first half of 1977).

Ms Huber described as "encouraging," however, the fact that there had been a decrease in drug abuse among young people aged 14 to 25. The number in 1976 was 44.6% lower than in 1969.

Last year, according to the minister, 388 young West Germans died as the direct result of drug abuse. The figure for the first quarter of 1977 was 58.

Those statistics, however, do not coincide with a report from West Berlin where there has been a sharp rise in narcotics use and abuse, especially heroin.

According to that city-state's minister of health, Ilse Reichel, there are "between 2,000 and 4,000 heroin addicts" in West Berlin. Since the beginning of 1977, 54 have died of over-doses.

The increase in Berlin is attributed partly to the comparatively low price for heroin there — DM 160-200 ($70 - $88 (US) compared to DM 300 to DM 400 ($132 to $176) per gram elsewhere in West Germany.

Much of the heroin is believed to enter West Berlin with Turkish guest workers.

In rehabilitation of alcoholics

Work therapy works: USSR

MUNICH— The Soviet Union has reported a successful technique of rehabilitating alcoholics through work therapy.

According to the weekly *Sotsialisticheskaya Industriya*, (Socialist Industry), a management paper, credit for this form of treatment is due to P. V. Zvorykin, the director of a glass works, who set up the first 100-bed section for on-the-job recovery of alcoholics in 1969.

Though Zvorykin's factory is a medium-sized enterprise by Soviet standards, the treatment section was enlarged to 400 beds in 1973.

According to *Sotsialisticheskaya Industriya*, there are "quite a number of such subsidiaries" of psychiatric hospitals for treating alcoholics at their places of work. The method, according to Soviet sources, was unique when first adopted in 1969. The treatment sections of the factories are run in cooperation with local or regional psychiatric clinics.

Patients taking part in work therapy do not receive their salaries directly. Forty percent is paid out to the clinic, the remainder either to the patient's family or, in some cases, to the patient himself when he is discharged from the clinic.

Experts on Soviet affairs here believe that Zvorykin's motives in setting up the treatment section were not solely humanitarian but also economic.

The USSR has a chronic labor shortage. In setting up the special section in cooperation with a local clinic, he was able to keep alcoholics in his factory's employ, and in enlarging the section was able to offer placement to alcoholics dismissed from other work.

Sotsialisticheskaya Industriya described Zworykin as "a sensible businessmen who realized long ago that such an investment promises concrete benefits for the factory concerned."

UK pro's set example

LONDON — A new British study shows that health professionals and teachers feel a personal responsibility for discouraging smoking by their own example.

Many of them, notably general medical practitioners, have themselves managed to give up smoking, and the level of smoking in their groups is much lower than in the general population — in some cases, 20%-30% lower.

These are the findings of a survey carried out for Britain's department of health and social security by the authoritative Opinion Research Centre under the supervision of the Office of Population Censuses and Surveys.

The survey was designed to analyze the smoking habits and attitude to anti-smoking education of a wide range of health professionals and teachers who, by the very nature of their work, could have an important influence on the public.

The report, called "Smoking and Professional People", concludes that most professionals felt they could make a personal contribution to anti-smoking education, and doctors and teachers were considered to be the most successful.

The general view was that the danger of lung cancer should be the main target of anti-smoking education, followed by bronchitis and heart disease, with particular reference also to dangers to the unborn child.

Chronic alcoholics don't adjust to high intake

By Lynn Payer

PARIS — A study of the medical records of drivers who had lost their licences for either accidents or driving violations found that the higher the alcohol blood level, the more likely the licence was lost because of an accident.

Moreover, for equal alcohol blood levels, chronic drinkers had a higher proportion of accidents than did occasional drinkers.

"The idea that chronic drinkers adjust to and are resistant to certain levels of alcohol is not born out," said the authors of the study, R. Vieville and H. Sapin-Jaloustre, writing in recent issues of *Le Concours Medical*.

"The problems associated with chronic heavy drinking seem to simply add to those of acute heavy drinking."

The authors emphasized that because of the nature of their study, only general ideas and not valid statistics could be found in it. Every driver in France whose licence is taken away, whether for having caused an accident or for an infraction such as speeding, must undergo a medical examination before getting another, and Drs Vieville and Sapin-Jaloustre simply chose a random sample of 1,300 dossiers made for such drivers from 1972 to 1975.

They were struck by the role of alcohol, they said: alcoholism of one kind or another was found in 959 of the 1,300. In contrast, the finding of other disease was relatively rare. Poor visual acuity was found in 11.5% and high blood pressure in 10.6%. These two conditions were found more frequently in conjunction with chronic heavy drinking: nearly 50% of this group were hypertensive.

When those dossiers in which the level of the alcohol test had been recorded were examined, it was found that only 42.7% of the sober drivers had their licence recalled because of accident whereas it rose to 81.1% in those testing at a blood alcohol level above 1.20 grams. In the group testing between 0.8 and 1.19 grams accidents were responsible in 65.9%.

However, the severity of accidents tended to diminish with blood alcohol level. The proportion of accidents in which someone was killed or injured was 66.1% in sober drivers and 21.9% in those with a blood alcohol of 1.20 grams or greater.

This could be explained in part, the authors said, in that the younger age groups tended to be those that caused the highest percentage of fatal accidents, due partly to their tendency to speed; whereas blood alcohol levels were higher in the older drivers. Also, they noted that drivers killed in accidents of their own causing could not be included in the study.

Because of their greater number of accidents, however, drinking drivers were still more likely to have caused an accident in which someone was killed or injured.

French student study: 2% smoke 'grass'

PARIS — More than two percent of college and university students in France smoke "grass" regularly, according to a recent survey.

(According to definitions used in the study "grass" meant either hashish or marijuana. In France, however, it is more likely to mean hashish.)

In addition to the two percent regular users, 11.3% of students said they were occasional smokers, and an additional 12% admitted to having smoked at least once.

The questions on drug use were part of a much broader study that included questions on many aspects of student life including leisure, political views, sex life, living arrangements, etc. According to *Le Monde de l'Education*, it is the first exhaustive study of the French student population. Approximately 5,000 students, estimated to be one-half of one percent of the total, were questioned.

The study revealed few surprises as to which type of student was more likely to have used drugs. Parisians were more likely to have smoked grass than provincials; arts and literature students were more likely than others; and grass smokers tended to be less satisfied with their studies, and to have a less clear idea of what they were preparing for after university.

Students who smoked grass were much more likely than non-users to have at least experimented with hard drugs (66.6% as opposed to 2.9%).

However, in a country that tends to polarize sharply along political lines, polarization was not reflected in drug use patterns. Grass smokers were more likely to be on the extreme left, the extreme right, or "ecologists", a term with more political than occupational overtones in France. Hard drug use followed the same pattern except with the ecologists whose hard drug use was low, probably reflecting, according to the study, the fact that this group makes a strong distinction between soft and hard drugs.

The traditional right had the lowest drug use and the traditional left (usually referring to socialists and communists) was between the traditional right and the extremists but closer to the traditional right.

A majority of students said that they were tolerant of soft drug use even if they didn't use them personally. Nearly 40% admitted to regular tobacco use.

Drug firms, doctors criticized

Drug trials should include elderly

By Alan Massam

BIRMINGHAM,UK — Family doctors here have been taken to task for the degree to which they overprescribe or allow themselves to be unduly influenced by the extravagant claims of pharmaceutical manufacturers.

The latest expressions of concern about the consumption of medical drugs came at the annual meeting in Birmingham of the British Association for the Advancement of Science.

William MacLennan, senior lecturer in geriatric medicine at the University of Southampton, told the meeting it was only comparitively recently that doctors and pharmacists had come to recognize that the treatment of elderly patients with drugs presented certain problems which were either not encountered or much less common among younger adults.

"An extreme example is the individual who collects all his medicaments in one jar and takes a tablet whenever he feels unwell," he said. "Again, there is the individual who takes all his hypotensive tablets when he awakes and spends the rest of the morning confined to bed with severe postural hypotension. These examples are extremes, but various investigations have shown that errors are extremely common."

Dr MacLennan said another major problem was polypharmacy. He referred to the study of Gibson and O'Hare in 1968 which showed that more than 10% of patients admitted to a unit for geriatric patients were taking five or more different drugs each day.

"There are, of course, many disadvantages in being on a complex drug regime," he said. "The most obvious is that it becomes almost impossible for elderly patients to follow instructions. It is equally obvious that the more drugs a patient is on, the more likely he is to develop an adverse drug reaction to one of them. The risk, in fact, increases geometrically rather than arithmetically. This may be due to the fact that many drugs in addition to interacting with the body tissues also interact with each other."

The speaker added that one of the many reasons for the high prevalence of side effects in old age was that most drugs trials were conducted in young or middle aged adults. Even when elderly patients were studied they were usually considered as part of an overall trial rather than as a separate group.

"In view of the wide range of physiological changes now demonstrable in old age this policy would appear misguided, and there is increasing need for studies in the elderly to be incorporated as part of the assessment of any new drug being introduced to the market," he said.

David Warburton, reader in psychology at the University of Reading, told the conference that drug use had increased "enormously" over the last 20 years in Britain. Referring specifically to tranquillizers, antidepressants and sleeping tablets, he said that while he would not suggest that psychoactive drugs did not form an essential part of effective therapy for psychiatric disorders, he was concerned about their use for helping patients cope with "the everyday problems of life."

"We have all been taught that drugs can provide the perfect remedy for our anxieties, depressions and sleeplessness," he said. "The source of this myth is advertising from the pharmaceutical industry. It fosters the belief that drugs are useful, not only for the seriously disturbed, but also for minor variations in mood and for minor anxieties. Every doctor is bombarded with propaganda about compounds for this purpose. Most doctors in Britain (90%) acknowledge that drug firm literature forms their main source of information about drugs.

"Even if a doctor is sceptical of a specific product the general message gets through to him — drugs should be used for a whole range of minor symptoms."

Dr Warburton said drug firms were obviously out to sell their products and obviously wished to draw the attention of doctors to them. It was estimated that Hoffmann La Roche had spent over £220 million on the promotion of Librium and Valium, and doctors had been persuaded to prescribe them for the slightest symptoms of anxiety.

In the vast majority of cases these compounds were being prescribed for conditions that would respond to simple reassurance or improve spontaneously. "This is internal pollution that results from drug advertising to doctors," he said.

Around the World

Hard work

The British and the Irish have to work harder to earn the price of a glass of beer than any of their Common Market cousins. Figures published by the EEC in Brussels reveal the average Irishman has to work for 28½ minutes to earn a litre of beer while the Briton must work for 24 minutes. West Germans put in 18 minutes, 11 seconds labor per litre, and the Luxembourger has to work for only nine minutes, six seconds. For a bottle of whisky, the Irishman must work four hours, six minutes and 11 seconds, but the Luxembourger can buy the same bottle after only one hour, 35 minutes, and 10 seconds.

French campaign

Tobacco sales in France dropped 3% after a government anti-smoking campaign on television and in the press began one year ago. That compares with an annual rise of 5% over the past 10 years. Market research showed the campaign increased the number of non-smokers from 41% to 43%. Between 10% and 15% of smokers said they smoked less after the campaign which counterattacked the 'virile' image of smokers as portrayed in cigarette ads.

High and low

High tar cigarettes accounted for only 0.4% of all cigarette sales in Britain last year, according to figures released by the department of health and social security. Smokers have been switching to lower tar brands since 1973, the DHSS statistics show. Middle to high tar brands took 10.5% of all sales last year, and middle tar took 70.1%. Low tar and low to middle tar cigarettes which have been rising in popularity in recent years, took 7.2% and 11.8% of the market respectively.

30 cigars each

Britons are smoking more cigars than ever before — more than 1,600,000,000 of them in 1976. That's a consumption rate of about 30 cigars per person per year, and over the next 10 years, the figure should rise to 50 or 60 cigars each, trade experts speculate.

AMPT and FA show promise in heroin addicts

By David Milne

TOKYO — Two drugs with widely different chemical structures but the same physiologic action have emerged as top contenders in the fight against drug addiction.

And if a way can be found to administer them in sufficiently large doses, both will be 100% effective in abolishing the craving and preventing withdrawal in heroin and/or amphetamine addiction, says Jose Pozuelo, head of narcotics research in the department of psychiatry, the Cleveland Clinic Foundation.

The agents are alpha-methyl-para-tyrosine (AMPT) and fusaric acid (FA), both of which have been used as anti-hypertensive agents.

Dr Pozuelo's work with the two agents was first reported in (**The Journal**, June, 1976), and although he felt word of his investigations had leaked out a little early, he later described his findings as a "tremendous step" in the treatment of addiction (**The Journal**, October, 1976).

In a pilot study reported here by Dr Pozuelo at an International Medical Symposium on Alcohol and Drug Dependence sponsored by the International Council on Alcohol and Addiction, all but three of 21 addicts lost their craving for heroin or amphetamines after only 10 to 15 days of treatment.

Dr Pozuelo suggested that the three failures did not respond because they were unwittingly given half-strength AMPT or FA, or were later given narcotics at another hospital.

Otherwise the trial was a complete success, he said.

The group consisted of 12 men and nine women from 18 to 60 years of age with histories of heavy drug addiction for from four to 18 years.

Fourteen were heroin addicts and seven were amphetamine addicts. All had an extremely high levels of tolerance measured by the large amounts of drugs needed to satisfy their craving and to prevent withdrawal symptoms.

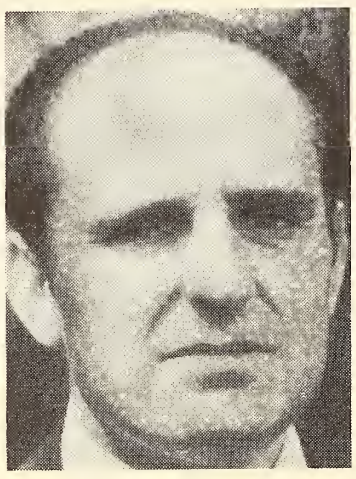
All were permitted to use heroin or amphetamines while they were being treated with AMPT or FA, until they lost their craving.

"The outstanding properties of AMPT and FA are that they not only abolish craving but also prevent withdrawal symptoms," said Dr Pozuelo. None of the patients experienced withdrawal as their desire for drugs waned and was finally eliminated.

"Another advantage is the short treatment time. Craving for drugs is usually abolished after only two weeks, but the patients are kept on medication for another 10 days," he said.

And unlike treatment with Naloxone and Naltrexone — two narcotic antagonists attracting interest among drug abuse workers — AMPT and FA do not induce withdrawal or produce aversion to narcotics.

The major problems hindering wider use of these agents are the large dosages required, which are based on the addict's tolerance to narcotics rather than body weight, and the difficulty of preparing these large doses in appropriate dosage forms.



Jose Pozuelo

Although amphetamine users require smaller doses than heroin addicts, the amount needed by some addicts may be as high as 16 gm a day. This is more than can be given safely to some patients, said Dr Pozuelo, because to handle such doses the patient's kidney's must be in top shape.

So far the side effects with the agents have been minimal, but the condition of an addict's kidneys will be a key factor in whether or not he can be treated by this method.

Both agents are known to act on catecholamines, and thus modify neurotransmitters levels. It is thought that levels of these neurotransmitters are increased in drug addiction, and AMPT and FA act by reducing them to normal levels thus eliminating craving for drugs. But this is thought to be only one aspect of the drug's mechanism of action.

In Dr Pozuelo's trial, the patients were followed for from 12 to 20 months. Four of 18 returned to drug abuse, but none of "the returns" were due to craving for drugs. Three of the four went back because of a "bad environment", and the fourth was mistakenly given drugs at another hospital for another reason.

Two side effects are minimal lowering of blood pressure, and, in the case of FA, there may be severe depression in some patients if the drug is administered for a long period of time.

Currently Dr Pozuelo is awaiting FDA approval for further clinical trials. He says he is confident the problem of dose size and formulation can be solved.

Co-worker in the study was May M. de Ybarra, MS.

Interlock—Canadian model?

NEW YORK — The lack of occupational alcoholism programs in British Columbia has led to the formation of Interlock, an agency that could serve as a model for the rest of Canada, according to Director Joan Lynch.

Ms Lynch told **The Journal** the first industrial programs in BC were formed 20 or 30 years ago, but it wasn't until this decade that programs for employees with alcohol or other drug problems received widespread attention from industry, unions, government, and community services.

"The few people who were operating industrial programs in the province were getting many requests from both the government and the private sector for assistance in establishing similar programs."

Ms Lynch said the objectives of Interlock were three-fold:

- to extend services to smaller organizations that could not otherwise have coordinators of occupational programs;
- to establish an organizational base for effective communication among representatives of management, labor, program coordinators, the Alcohol and Drug Commission, government, education, and community services; and,
- to provide opportunities for the training of industrial coordinators currently operating programs; and for those wishing to become coordinators.

"One fact I find really encouraging in BC is that we have a lot of support in the labor movement," she concluded. "I'm pleased at the positive response from people in unions and will probably spend as much time focusing on unions as on management."

Anti-smoking plans laid

WASHINGTON — Some 30 proposals for a new American government drive on smoking are currently being considered by Joseph Califano, Secretary of Health, Education and Welfare, before being sent to President Jimmy Carter.

They range from a "Don't Smoke Day" each year, with no smoking or sale of cigarettes, to the setting of a maximum tar and nicotine level in cigarettes.

The detailed proposals are expected to be made public some time in the new year.

There are indications, however, that few if any of the proposals, drawn up by an HEW task force headed by Surgeon General Julius Richmond, will see the light of day.

Although Mr Califano, an ex-smoker, favors more action, President Carter in the past has said he is not in favor of more government involvement in the smoking and health field.

Congress, in addition, has balked previously at some similar proposals, and the tobacco industry lobby is strong in both legislative chambers.

Among the other proposals:

- An education program for both primary and secondary schools.
- Stronger warning of health dangers on cigarette packets.
- Reduction of smoking in public places, especially government buildings.
- Increased excise tax on cigarettes.

Kink added to BAL law in Sask

REGINA — Drivers in Saskatchewan with a blood-alcohol level of 0.06% or above now face a 24-hour suspension of their licence.

The level at which drivers can be charged with impaired driving, and have their licence suspended for six months under the Criminal Code, remains at 0.08%.

The law lowering the threshold for 24-hour suspension to 0.06 from 0.08% has been on Saskatchewan's books since 1969, but wasn't proclaimed until Oct. 15 of this year.

An increase in the number of drivers caught on the road with a blood-alcohol level of 0.08%, and a close study of the level at which people became impaired, convinced the government that police needed additional weapons to deal with the problem of drinking drivers, Saskatchewan Attorney-General Roy Romanow said.

pcp pcp pcp pcp pcp pcp

factsheet

Reports from the street drug analysis facilities of the Addiction Research Foundation of Ontario have emphasized that the misrepresentation of drug substances on the street is extremely common and widespread. In 1974, for example, substances coming to the Foundation's attention which were sold as mescaline, THC (tetrahydrocannabinol — the ingredient in marijuana and hashish producing the typical effects on mood and perception) or peyote, contained no such drugs. However 73% of these samples revealed the presence of the drug phencyclidine (PCP). In fact, after cannabis, phencyclidine was the drug most frequently encountered in street samples analyzed by the Addiction Research Foundation in 1975.

PCP has been found on the street since 1967, when it first appeared as the 'Peace Pill'. It has various street pseudonyms such as Angel Dust, Hog, Horse Tranquillizer, and Animal Tranquillizer. Often, phencyclidine is found with another drug, eg LSD and PCP.

Phencyclidine is a synthetic drug, chemically unrelated to either LSD or mescaline. Originally developed as an intravenous anesthetic for human use, PCP was discarded due to its considerable undesirable side effects — such as convulsions during surgery, and after effects of delirium, visual disturbances, and agitated behavior.

These effects led to research involving PCP's possible use in psychiatry, but it was completely withdrawn from human use because the drug was found to be of only limited benefit in the treatment of psychiatric illness. Currently, PCP is legally marketed only as a general anesthetic for use in veterinary medicine.

APPEARANCE

Phencyclidine hydrochloride (PCP) is a white, crystalline powder readily soluble in water or alcohol. As a street drug, PCP may be smoked, injected, ingested as a liquid, or taken in tablets and capsules in many sizes, colors, and dosages.

EFFECTS

As with any drug, the effects of PCP depend on the amount consumed, the method of ingesting the drug, and the circumstances in which the drug is taken; the place, the feelings of the user, the other people present.

In humans, phencyclidine is a difficult drug to accurately classify since it produces different kinds of effects at different dosages. The effects may resemble those of a stimulant, a pain-killer, an anesthetic, or an hallucinogen. Not all people react in the same manner to the drug, even under similar dosages. Reactions as different as stupor and euphoria have been observed in experimental studies.

An intravenous injection of PCP will produce effects within a few minutes. In order to get the same effects by ingesting the drug orally, one would have to take more of the drug and wait a longer period of time. Acute effects are usually over within a matter of hours.

It has been suggested that PCP acts primarily on the sensory cortex, thalamus, and the mid-brain in such a manner as to inhibit an individual's ability to integrate internal and external information. The drug seems to be able to bring out individual psychopathology which may previously have been hidden. People who have taken PCP often lose their ability to sustain directed thought and to think sequentially while affected by the drug. Frequently, individuals exhibit negative feelings or outright hostility to their surroundings.

A particular concern with phencyclidine is one that extends to all street drugs. The user cannot tell by casual inspection whether or not a substance is the desired drug. One may expect the relatively mild effects of mescaline or peyote when the purchase takes place under these names. More likely, the user experiences the more unpleasant and unpredictable effects of PCP, or of PCP in combination with some other drug such as LSD. Moreover, since the content of PCP varies considerably from one street product to another, the intensity and duration of the drug's effects are also quite unpredictable.

It is apparent that while phencyclidine in a low dose may produce a relatively pleasant experience for some users, higher doses present very real risks, including death. While only a few samples have been analyzed quantitatively in the ARF street drug laboratory, the phencyclidine content has ranged from 1.3 mg to 81 mg per unit dose. For the experimental use of PCP in psychiatric treatment the dose ranged from 5 mg to 15 mg.

SHORT TERM EFFECTS are those which appear rapidly after PCP is taken and disappear after a few hours or a day.

In low dosages, PCP causes a slight increase in a person's rate of breathing, and respiration becomes shallow. There is a more noticeable increase in blood pressure and pulse rate. Flushing and profuse sweating frequently follow ingestion of the drug. Generalized numbness of the extremities and muscular incoordination also occur.

At higher dosages, there is a fall in blood pressure, pulse rate, and respiration. This is accompanied by nausea, vomiting, blurred vision, rolling movement and watering of the eyes, loss of balance, and dizziness.

Large amounts of the drug can cause convulsions and coma, and several deaths have been associated with PCP ingestion.

After ingesting a low dosage of PCP, a user will feel distinct changes in body awareness. Feelings have been described as similar to those occurring with alcohol intoxication. At slightly higher dosages, the effects of PCP mimic certain primary symptoms of schizophrenia. Delusions and mental confusion are common. There is a feeling of distance from one's environment. Illusions (perceiving stimuli from the external world in a distorted way) and/or hallucinations (hearing or seeing things that are not there) have been reported when high dosages of phencyclidine were administered.

LONG TERM EFFECTS are those provoked by repeated use over a long period of time. While some long term effects result from the frequent repetition of short term effects, others occur only over a long period and may not be predictable from the short term effects. At present, little is known about the effects of phencyclidine which result from frequent or repeated use over an extended period of time. However, since some of the effects of PCP and the hallucinogens are similar, one could reasonably ask whether or not similar hazards are present. In particular, the phenomenon of flashbacks (where the sensations of an LSD experience, for example, re-occur sometime after taking the drug) should be of concern. Periods of prolonged anxiety or severe depression could also occur.

PHENCYCLIDINE AND THE LAW

Legal penalties for the possession, selling, importing, and exporting of phencyclidine are included in the Narcotic Control Act. A summary conviction for possession (first offense) carries a penalty of up to $1,000 and/or six months imprisonment. An indictable conviction for possession may result in imprisonment for up to seven years. The decision whether an offense is summary or indictable rests with the Crown and varies with individual circumstances such as the type and amount of the drug. Possession for the purposes of trafficking is an indictable offense and, according to the Narcotic Control Act, conviction may result in a prison term of up to life. Conviction for either importing or exporting phencyclidine will result in a sentence of from seven years to life.

The Journal

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Clip this page

New Books

by RON HALL

Cocaine: 1977

. . . edited by Robert C. Petersen and Richard C. Stillman

This volume summarizes the admittedly limited knowledge of cocaine through a series of reports by leading workers in the area. They range from animal behaviorists conducting research at the preclinical level to clinicians contending with the problems of the street user. Chapters have been devoted to a non-technical review of the present knowledge, brief historical review, the chemistry of cocaine, animal behavioral research, the effects of cocaine in man, recreational use and intoxication, forensic toxicology, current uses of cocaine in clinical medicine, and a description of the drug abuse treatment monitoring system. It is hoped that this book will serve not only as a useful reference work for clinicians and scientists, but also that it will become a useful document for those interested in applying modern scientific knowledge to the social policy questions associated with cocaine use.

(National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland, 20852. 1977 231p. $3.)

The Epidemiology of Drug Abuse: Current Issues

. . . edited by Louise G. Richards and Louise B. Blevens

This monograph contains a collection of edited transcripts from the Conference on the Current Issues in the Epidemiology of Drug Abuse held in Miami Beach. Nov 18-19, 1974. The purpose of the conference was to review the state of research at the time, identify major problems and gaps, and recommend new directions that should be taken. The topics which are addressed in this book include: issues underlying incidence and prevalence, problems in data acquisition, problems related to applying and extrapolating data, and current epidemiology programs and recommendations.

(National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland, 20852. 1977. 240p. $2.60).

Behind the Wall Of Respect
Community Experiments in Heroin Addiction Control

. . . by Patrick H. Hughes

In this book, the author presents information on his work in one of Chicago's oldest "copping areas", where heroin had been sold for more than 20 years. Epidemiological observations of active addicts in their natural surroundings suggested intervention projects which were conducted from 1968 to 1974 in six high drug use neighborhoods of varied ethnic makeup. By going into the community, finding and monitoring all known and new cases of addiction, and making treatment attractive and convenient to all addicts, field teams can check the spread of the disease. The culmination of the work was the Altgeld Gardens program which converted an "epidemic" neighborhood into a community relatively free of heroin addicts. The book covers such diverse issues as the dynamics of the street addict subculture, work with militant community leaders, selection of staff, structuring of the treatment milieu, and location of facilities.

(The University of Chicago Press, 5801 Ellis Avenue, Chicago, Illinois, 60637. 1977. 182p. $10.95).

Other Books

The A To Z System: A Unique New Technique For The Cure of Alcoholism — Scanlan, Edwin L. Dorrance and Company, Philadelphia, 1976. 105p. $5.

Human Health And Disease — Altman, Philip L, and Katz, Dorothy Dittmer (eds). Federation of American Societies for Experimental Biology, Bethesda, 1977. Infectious diseases, immunological factors, metabolic disorders, organ system diseases, neurologic diseases, endocrinology and endocrinopathies, radiation and radiobiology, index. 435p. $45.

Drugs, Rituals And Altered States Of Consciousness — DuToit, Brian M (ed). A. A. Balkema, Rotterdam, 1977. Drug use and cultural patterning, modern urban America, hallucinogens and sensory stimulations, future research. 272p. $16.50.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

DWI Decision

Subject Heading: Impaired driving. Alcohol-Pharmacology.
Details: 25 minutes, 16 mm, color, sound.
Synopsis: This animated film explains how alcohol affects those who drink, and discusses myths about drinking and driving. Transactional Analysis is used to explain how alcohol interferes with decision making and judgment. After the factual information has been imparted we see some young people driving home from a fair after drinking. Their van is involved in an accident. The driver cannot explain how the accident happened.
General Evaluation: Fair to good (3.5).
Recommended Use: Not appropriate for those under 12 years of age. Could be of benefit to all others.

Listen, Listen, Listen

Subject Heading: Treatment/rehabilitation, attitudes and values.
Details: 83 minutes, 16 mm, color, sound.
Synopsis: This film documents one man's approach to the treatment of delinquent young people in a residential setting. The leader's style of confrontation and rule setting are shown. The young people's reactions and how they feel about living in his community are also explored.
General Evaluation: Fair to good (3.6).
Recommended Use: Adult audiences, espeically those involved with juvenile delinquents.

The Man Upstairs

Subject Heading: Skid Row trigger film. Attitudes and values.
Details: Six minutes, 16 mm, black/white, sound.
Synopsis: A series of glimpses of life in an inner city park in Toronto, including skid row residents, religious groups, and eccentrics.
General Evaluation: Fair to good (3.6).
Recommended Use: With the presence of a resource person, the film could benefit audiences of 15 years of age and older. Especially useful for those working with skid row residents.

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Coming Events

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Canada

21st annual Toc Alpha Christmas Conference — Dec 27-30, 1977, Don Mills, Ontario. Information: Toc Alpha, Suite 603, 15 Gervais Drive, Don Mills, Ont, M3C 1Y8.

Detox Workers Training Program — Jan 23-27, Feb 20-24, April 24-28, 1977, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario, 33 Russell Street, Tor, Ont, M5S 2S1.

10th Banff International Conference on Behavior Modification — March 19-23, 1978, Banff, Alberta. Information: Donna Fraser, coordinator, Banff International Conference on Behavior Modification, 603, 733-14th Avenue SW, Calgary, Alta.

United States

2nd Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, 1977, Atlanta, Georgia. Information: Conway Hunter Jr, Peachford Hospital, 2151 Peachford Road, Atlanta, Georgia, 30366.

North Carolina Conference on Women and Alcohol — Dec 9, 1977, Fayetteville, NC. Information: Nancy Formy-Duval, Cumberland County Addictions Services, 902 Southern Avenue, Fayetteville, NC, 28306.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC-78, 200 Broadway, Seattle, Wash, 98122.

International Arctic Rim Conference on Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Abroad

3rd Arab International Conference on Alcoholism and Drug Abuse — Dec 3-7, 1977, Khartoum, Sudan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th Columbo Plan Consultative Committee Meeting — Dec 1977. Information: The Columbo Plan Bureau, 12 Melbourne Avenue, Columbo 4, Sri Lanka.

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside, Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street. Liverpool, L2, 5RU, England.

International Conference on Alcoholism and Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute on the Prevention and Treatment of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

It's a social necessity

Qat chewing still vital to North Yemen life

By Peter Wood

North Yemen afternoons are devoted to chewing the leaves of the qat plant which, users say, produces a sense of euphoria, later replaced by a feeling of torpor. Above: Man chewing and selling qat in Taiz Market, North Yemen.

Photos: Trevor Mostyn

AFTERNOONS in North Yemen are a time for chewing the leaves of the qat plant. Between two and five o'clock, most adult males, and many women as well, in this mountainous southwest corner of the Arabian Peninsula, sit in groups, reducing bundles of qat leaves in their mouths to a dry paste.

The three hours are for socializing, and social life without qat in North Yemen is unthinkable. *Qat* is the vital stimulant to good conversation.

Qat parties usually take place in the *mufraj*, a large reception room at the top of the tall Yemeni houses. Its white-washed walls are lined with mattresses and cushions, on which each chewer reclines within easy reach of a thermos of cinnamon-flavored, iced water and a hubble-bubble. Everyone brings his own qat, bought in the market in bunches wrapped in grass. The leaves are spread on a table cloth then shaved, each person accumulating enough to make one cheek bulge out like a balloon. The munching and talking begin.

People who have chewed qat say it produces a sense of euphoria, later replaced by a feeling of torpor.

"At first you feel very optimistic and think all your problems are soluble," said one Yemeni. "Your imagination is stimulated, and you become mentally active. Then after about two hours, your limbs feel cold and you are overcome by depression."

The Yemenis talk a lot about the powers of qat to make them speak eloquently and with great friendliness. They claim much fine poetry has been written under its influence.

Officially qat is not classified as addictive. When the World Health Organization Committee on Addiction Producing Drugs studied it in 1964, they were undecided about its addictive powers. Devotees, the committee concluded, can become mentally dependent on the drug but, unlike those addicted to most narcotics, do not suffer a physical relapse when it is suddenly withdrawn. Nor does it give a distorted view of reality as does hashish.

Some governments do not even consider it to be a narcotic. A Yemeni recently handed over a bundle of qat to the British customs officers at London's Heathrow Airport. After a laboratory test, he was allowed to take it through.

Nonetheless, it has been thought to be dangerous enough to be banned in other Middle East countries and African states where it is common. Saudi Arabia, Sudan, and Egypt have prohibited its use and cultivation. South Yemen has been trying to stamp out the chewing habit. The Aden Government has banned qat imports from North Yemen and introduced a system of strict price controls. Ethiopia, where the plant originated in the 11th century, has refused to ban it, arguing that since it is not classed as addictive, it does not need to be prohibited. Successive governments in North Yemen, where the drug is most widely used, have taken a similar view.

The leaves and green stems of the qat bush (*catha edulis*) contain groups of chemical compounds similar to those in amphetamines. Unappreciative foreigners who have visited North Yemen say they can avoid all the chewing and gain the same effect by swallowing a few Benzedrines. The plant also contains caffeine.

The top leaves of the bush, which ranges in height from five to 15 feet, are considered by the Yemenis to be of the best quality, apparently because of the high caffeine content. The leaves also have sugar, oils, tannin, and a high proportion of Vitamin C. One hundred grams of qat leaf is estimated to contain 150 milligrams of ascorbic acid.

Qat is not considered to have *serious* effects on health although a report by the United Nations' Food and Agriculture Organization (FAO) concluded that excessive use could cause loss of appetite, insomnia, gastritis, constipation, and piles. More worrying has been a recent finding that it can hinder lactation by women. Also the babies of mothers who took qat regularly were found to be suffering from constipation, loss of sleep, and dryness of the mouth — all symptoms related to qat chewing. Qat ingredients can obviously find their way into a mother's milk and Yemeni mothers are now being discouraged by health workers from chewing qat.

Qat's main harm is to the economy. North Yemen is one of the poorest countries in the Middle East. In 1975, the World Bank estimated its 6.4 million population had a per capita income of $210, compared to $3,010 in neighboring Saudi Arabia. Most economic experts who know the country well agree it could be much richer if such a high proportion of the population did not spend so much time chewing qat. Yemeni economist, Said Attar, has calculated that about 3,000 million working hours are lost each year through qat taking.

The country is predominantly agricultural. Agriculture accounts for two-thirds of its Gross Domestic Product and virtually all its exports are agricultural products. But the country does not export enough, and Saudi Arabia has to donate large sums to bridge the wide gap in the trade balance. Undoubtedly, it would be exporting more if extensive tracts of good farming land were not preserved for growing qat. Coffee — a major export — has to compete with qat for land and, since qat is much easier to grow and market, the coffee crop has been cut. More than 100,000 acres are estimated to be set aside for growing qat, compared with 18,500 for coffee and 70,000 for cotton, another important export.

The total annual value of qat production is thought to be at least $100 million or about 20% of all agricultural output. Proceeds are shared by an estimated 170,000 farmers who cultivate qat. A recent World Bank report concluded: "Stimulated by improved transport and increased demand from wage earners, qat has become for many farmers the main, if not the only, source of cash income."

View of the city of Ibb in southern North Yemen.

Farmers, in fact, cannot produce enough qat to satisfy demand. By Yemeni standards it fetches a high price on the open market. As a result, people spend a large proportion of their income on the drug. Swedish social anthropologist Annika Bornstein, who four years ago carried out a survey on qat taking on behalf of the FAO, found that more than 50% of men bought qat daily and that it was taking up between 20% and 50% of their income.

One man with a family of five, working in a bakery in Sanaa, the North Yemeni capital, was spending $540 a month on food and $270 on qat. A soldier with a wife and seven children spent $1,350 a month on food and $800 on qat. A sheikh with five children, who had his own agricultural land, had a monthly food budget of $2,250 and $700 set aside for qat.

Even if the present North Yemen government wanted to ban qat, it is doubtful it could. Qat is too deeply engrained in the country's way of life to make prohibition practical.

"For political and social reasons, the government cannot forbid the cultivation and use of qat at present," said Mahmoud Jamal Mohammad, the head of the Yemen Tourist Organization, in a recent interview.

"Most Yemenis see qat as a social necessity. They become frustrated if they cannot get hold of it. It doesn't make you drunk — it's not a drug. It's like drinking a pint of beer in the pub in Britain."

Instead of talking about its disadvantages, government officials, and even health experts, now tend to stress qat's benefits to North Yemeni society. It might be bad for exports, but it still provides an income not only for farmers but also for many Yemenis involved in its marketing.

Qat has to be chewed fresh, and the leaves used in the afternoon have usually been picked that morning on the terraced plots high in the mountains where the plant flourishes.

Distribution and marketing is a highly sophisticated operation in a country where communications are still, in many parts, relatively primitive. In some remote areas, it is even distributed by teams of men on motor bikes.

It is also claimed that qat has helped, at times, to bring comparative peace to a country which has often been riven by tribal strife and which only 15 years ago went through a bloody civil war. Dr Tigani el-Mahi, a WHO mental health advisor, has said: "It has contributed to the stability of the community by socializing leisure time and inhibiting agression. It has helped to create a group sentiment and has curbed anti-social behavior. A prohibition of qat would dislocate community life."

British health worker, Angela Coulter, who spent two years in North Yemen coordinating a British health aid program, was impressed how qat helped to break down social barriers.

"During qat sessions there was always an open house. Anyone could join in. Social divisions were forgotten. Our driver, who came from a mountain village, used to chew qat regularly with the minister of health with whom we worked closely. It is very difficult to be lonely in North Yemen."

If qat does lose its grip on Yemeni society, it may well be the result of creeping Westernization, rather than any prohibition. The ending of centuries of isolation in North Yemen has brought many Westerners into the country, a lot of them tourists lured by the country's remarkable beauty.

With the foreigners has come alcohol. The government has officially banned it among Yemenis because the country is Islamic. Nonetheless, it is permitted in hotels and is now being drunk frequently in private by richer Yemenis. Doctors are already beginning to deal with cases of alcoholism. And to young urban Yemenis, qat sessions are looking increasingly old-fashioned in an age of television and Western dress.

"Qat has to go sometime and when it does alcohol will take over," said Angela Coulter.

That could be a loss to Yemeni society. "Qat means friendship and eloquence, "said one Yemeni, "while alcohol brings aggression."

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